UNITED NATIONS SYSTEM CEB

Chief Executives Board for Coordination

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HIGH-LEVEL COMMITTEE ON MANAGEMENT (HLCM)
Thirty-Eighth session, 15-16 October 2019
UN System Staff College, Turin, Italy

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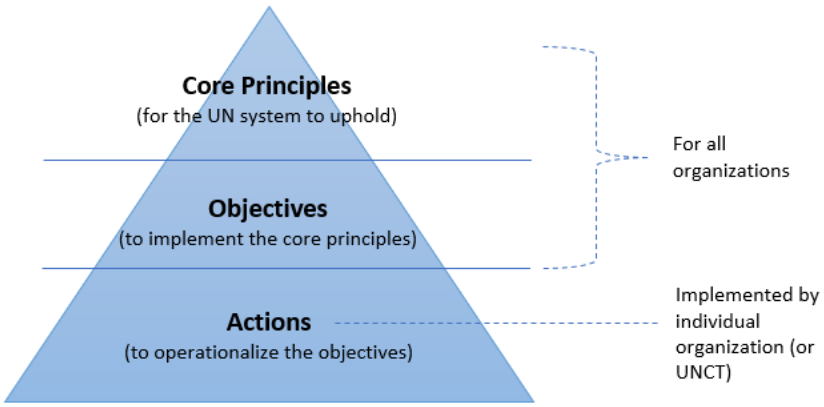
Annex 1. Core Principles for a healthier, safer, and more respectful UN workplace

Overarching objective: Creating an organizational culture that is conducive to promoting a healthy, safe and respectful work environment.



1. **Risk awareness and transparency**
   The Organization is proactive in providing information and is open to engagement, input and feedback from personnel.

   Objective:
   - Maintain a dynamic hazards and risks communication to staff and non-staff personnel, their eligible dependents and management at all times, before and throughout the deployment.
   - Ensure that staff, their eligible dependents, and non-staff personnel, where applicable, and management are fully aware of existing mitigating controls, level of effectiveness and any residual risks.
   - Ensure staff and non-staff personnel are informed of current and available information about the duty station (including medical and security situations) prior to, during and after deployment.

   Actions endorsed by HLCM under the Task Force:
   - Pre-deployment guide and resilience briefings
   - Country specific factsheets are made available and easily accessible

   Actions resulting from other HLCM- mandated activities:
   - Regularly updating and communicating the results of risk management processes (e.g. Enterprise Risk Management (ERM), Security Risk Management (SRM) and Occupational Safety and Health (OSH)

2. **Safe and healthy working and living environment**
   Shared engagement of the Organization and UN staff and non-staff personnel to promote and sustain security, safety, health and wellbeing of UN staff and non-staff personnel as far as it is reasonably practicable.

Objectives:

- Inform staff and non-staff personnel as well as management of their roles in the provision and maintenance of a safe, healthy and secure working and living environment
- Ensure that relevant health, safety and security provisions are made available and appropriately manage associated risks.
- Implement the HLCM-approved OSH Framework, which includes developing an OSH policy statement.
- Develop, review and test periodically emergency response preparedness plans..

Actions endorsed by HLCM under the Task Force:

- Duty Station health risk assessment and psychosocial health risk assessment
- Integrating OSH into ERM processes (under development)
- UN living and working standards
- Mental Health and Wellbeing Strategy

Actions resulting from other HLCM-mandated activities:

- Road safety strategy
- Prevention of all forms of exploitation, abuse and harassment
- Security Risk Management process (SRM)
- Programme Criticality
- Occupational Safety and Health Framework (OSH)

3. Inclusion and respect for dignity

Organizations treat all staff and non-staff personnel in good faith, with due consideration for individual circumstances, respecting and preserving dignity and diversity.

Objectives:

- Take into due consideration individual circumstances, as far as is reasonably practicable
- Create a work environment that is inclusive and free from discrimination, sexual exploitation and abuse, sexual harassment, harassment and abuse of authority
- Implement measures which promote a healthier, safer and more respectful UN workplace

Actions endorsed by the HLCM under the Task Force:

- Pre-deployment guide and resilience briefings
- UN living and working standards
- Measures for locally-recruited staff in high-risk environment
- Suggested practical OSH measures for affiliates/standby/non-UN personnel

Actions resulting from other HLCM initiatives and other UN bodies:

- Prevention of sexual exploitation and abuse
- Prevention of sexual harassment, harassment and abuse of authority
- Prevention of retaliation against whistleblowers
- Enabling workplace environment
- UN Convention on the Rights of Persons with Disability

- UN for ALL

4. Caring for consequences of risk

Caring for those who have been adversely affected or impacted by hazardous events associated with their work with the United Nations.

Objectives:

- Demonstrate empathy in all administrative actions
- Make every reasonable effort to accommodate those who have been adversely affected and/or impacted by hazardous events associated with working with the UN
- Mitigate any adverse impact associated with working with the UN

Actions endorsed by the HLCM under the Task Force:

- For eligible personnel, timeliness of delivery and clarity in the process related to compensation for service incurred injuries, illness and death (e.g. Appendix D in UN Staff Regulations and Rules)
- Measures for staff members who are no longer able to serve in high-risk environment
- Mental Health and Wellbeing Strategy
- Health Risk Assessment and Health Support Plans
- Training for managers who serve in high-risk environments (under development)

Actions resulting from other HLCM initiatives and other UN bodies:

- Critical Incident Response Service, UN Secretariat (UNDSS-CISMU and DMSPC/OHR)
- Ombudsman's office
- Healthcare Quality and Patient Safety (HQPS) standards

5. Accountability at all levels

Creating a just culture that supports effective leadership and individual accountability.

Objectives:

- Empowerment and involvement of staff and non-staff personnel, regardless of level, in OSH matters.
- Accountability framework for OSH

Actions endorsed by the HLCM under the Task Force:

- Integration of OSH into ERM processes, which will define the accountability at all levels
- Incorporation of OSH responsibilities under the Mutual Accountability Framework for Resident Coordinators (under development)
- Training for managers who serve in high-risk environments (under development)

Actions resulting from other HLCM initiatives and other UN bodies:

- The Framework of Accountability for the United Nations Security Management System
- United Nations Leadership Framework

Annex 2. Integration of Occupational Safety and Health into Enterprise Risk Management process

A. Checklist

Checklist: Integration of Occupational Safety and Health into Enterprise Risk Management			
Questions		**Yes**	**No**
1	Is there a functioning ERM system?		
2	Is the ERM system both top-down and bottom-up?		
3	Has the organization issued a formal OSH policy statement?		
4	Has the organization established an OSH management system?		
5	Is there an OSH oversight body?		
6	Are there local OSH committees/focal points?		
7	Has the organization identified OSH as a strategic organizational risk?		
8	Does the organizational risk register include a risk category which pertains to OSH?		
9	Is staff safety, health and welfare incorporated into the accountability framework for Heads of Offices/Representatives?		
10	Have instructions been provided to managers on how to integrate OSH into their periodic risk review?		
11	Does the organization conduct regular risk analysis in order to populate, manage and escalate relevant risks?		

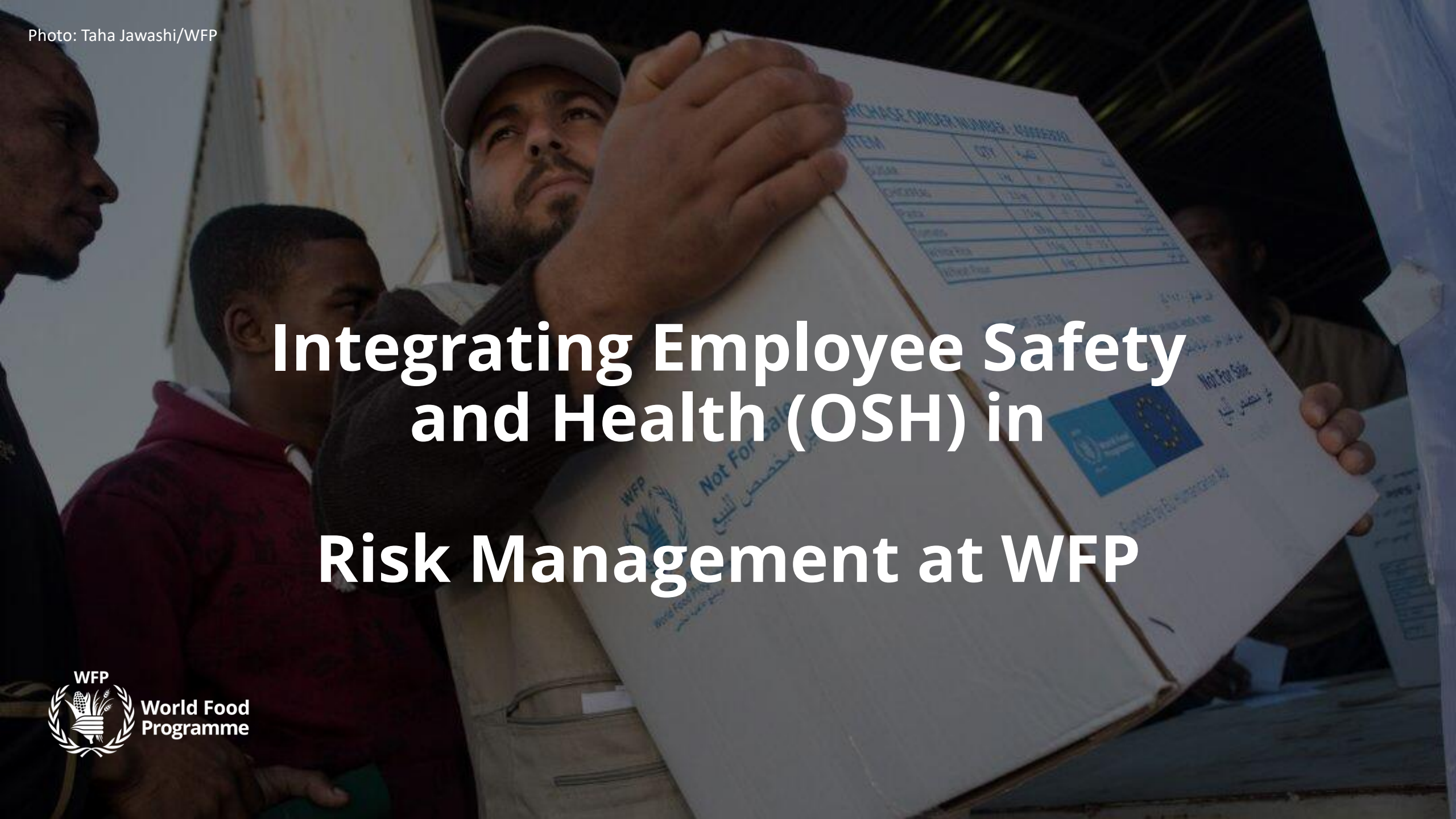
Annex 2. Integration of Occupational Safety and Health into Enterprise Risk Management process

B. Sample Occupational Safety and Health detailed risk categorization

Risk Category: Occupational Safety and Health (OSH)		
Hazard area	**Hazard**	**Description**
Physical trauma	MVA/Road traffic accidents	Vehicle collisions, crash injuries, head injuries, fractures, chest injuries, overcrowded vehicles, involvement of third parties, vehicle to vehicle, vehicle to motor cycle, vehicle to building, vehicle to person, vehicle to aircraft, road conditions, rollover, tire condition, removal of patients from crashed vehicle, air craft crash
	Malicious Act trauma	Gunshot wounds, blunt trauma, mines, injuries, shrapnel injuries, machete wounds, knife wounds, contusions, arrow wounds, burns, grenade explosions
	Occupational workplace injury	Falls, burns, various injuries
	Civil unrest	Injuries caused by such exposure
Infectious diseases	Vector borne	Malaria, Zika, Chikungunya, Yellow Fever, etc.
	Water Borne/Food Borne	Hepatitis A, Typhoid, Cholera, etc.
	Human to Human	STIs, Tuberculosis, Ebola virus disease, Meningitis, HIV, Measles, Hepatitis B, Hepatitis C
	Zoonotic (animal-human transmission)	Giardiasis/ Helminthiasis, Schistosomiasis, Amoebiasis, Rabies
Environmental factors	Air pollution	Second-hand smoke, air quality
	Temperature (heat/cold)	Dehydration, hypo/hyperthermia
	Envenomation	Scorpion sting, snake bite, bee sting
	Altitude	Altitude sickness
	Radiation	Diseases associated with radiation exposure
	Food/water sanitation	Considered under water and food borne infectious diseases
	Shelter / Accommodation	Accommodations below UN standards
	Natural disasters	Storms, floods, lightning, tornados, tsunamis, cyclones, hurricanes, seismic activity, etc.

Annex 2. Integration of Occupational Safety and Health into Enterprise Risk Management process

Hazard Area	Hazard	Hazard description
Psychosocial risk hazards	Exposure to critical incident	Critical incident is any event that can potentially cause primary trauma (car accident, attack, violent civil unrest, earthquake, etc.) which also may result in Post-Traumatic Stress Disorder (PTSD).
	Job content/ exposure to secondary trauma	Specific job profiles (such as dealing with emergencies, security, medical, refugees, etc.) which can expose staff to traumatic content (stories, images)
	Job control	The amount of control, decision or latitude one has over his/her daily work, i.e. what and how to do it, work pace, tasks, job priorities, work overload.
	Job demand	Amount of physical and psychological attention (cognitive, emotional) effort and attention needed to achieve tasks
	Job satisfaction	Feeling of satisfaction/fulfilment one has toward his/her job Along with job control and job demand can contribute to positive or negative motivation
	Working environment and equipment	Facilities, system in place to facilitate one's work Working hours, workloads, ergonomics, availability of space and equipment
	Effort reward imbalance	The reciprocity between the effort made in work and what is received in return Reward can be recognition, esteem, salary, promotion prospect, etc. High level of imbalance can lead to emotional distress, exhaustion
	Quality of social support	Interpersonal relationships at work and social life
	Home/work interaction	How positive or negative events at work impact one's life at home and vice versa
	Workplace violence	Abuse, threats, assault, harassment, sexual harassment, discrimination, management style, etc.



Integrating Employee Safety and Health (OSH) in Risk Management at WFP

WFP
World Food Programme


Photo: Olivia Acland/WFP

Agenda

1. Risk Management overview
2. New risk categorizations
3. OSH Risk Review
4. Risk appetite statement
5. Risk performance indicators
6. Where to go next?

Risk Management overview

What is WFP's policy on risk management?

Sets WFP's **vision for risk management**: creating a culture of proactive, systematic risk identification & management

Presents **new risk categorizations**: Strategic, Operational, Fiduciary & Financial

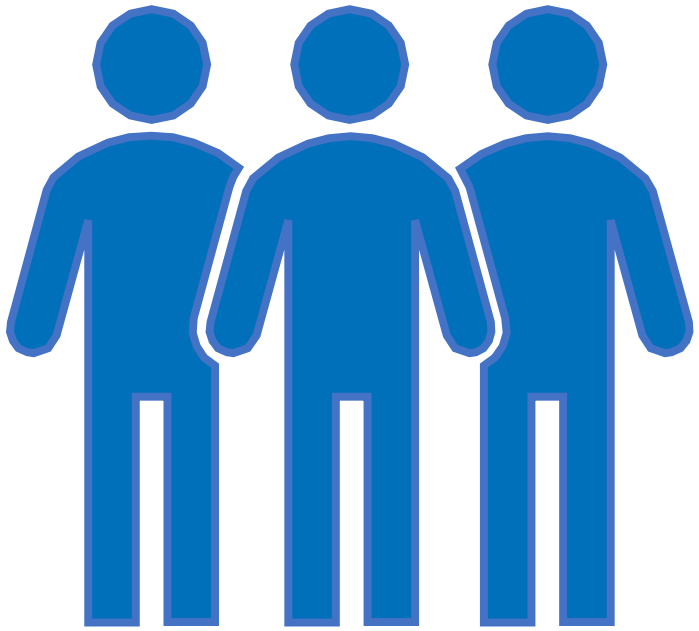
Outlines **updated risk appetite statements**, & provides a basis for developing new risk metrics

Presents **updated roles, responsibilities & accountabilities for risk management** at all levels (building upon the 2018 Oversight Framework, WFP/EB.A/2018/5-C)

Defines **risk management processes** at corporate, office and functional levels & new elements including risk escalation/reporting

WFP/EB.2/2018/5-C

sks on a regular basis.



Who is responsible?

Everyone is responsible for managing risks in their day-to-day activities.

WFP's enterprise risk management framework has three key levels:

- **Functional**: functional area or process level (e.g. Cash Based Transfers risk mgmt. tools)
- **Unit/Office**: portfolio view of risks for a unit or Country Office (e.g. Country Office Risk Register)
- **Corporate**: cross-cutting, strategic or emerging risks centrally managed or monitored

Risk Management Cycle

- Risk appetite statement
- Yearly cycle synchronised with Annual Performance Plan
- Risk performance indicators monitored quarterly against performance intervals

Key steps:

1. Identify the risk
2. Categorize the risk
3. Determine the risk seriousness using likelihood & impact
4. Identify existing measures & controls (activities already in place to help manage the risk)
5. Agree on mitigation actions (new activities to undertake to manage the risk)
6. Assign mitigation action owners
7. Determine if escalation of the risk/mitigation action is appropriate

Applying the ERM framework in the Country Office

Process level	Unit/Country Office level	Corporate level	
Completion of period functional risk reviews: • Emergency Preparedness Response Planning • Cash Based Transfers • Security • Aviation/UNHAS	Annual completion of risk review exercise & risk register	Submission of risk register and subsequent updates to RB and Risk Management Focal Points	
	Mid-year review of risk register		
	End-of-year review of risk register	Manage risk register in new risk management system	Coming in 2019!
Completion of Internal Control Self-Assessment Checklists by functional area	Regular review of mitigations actions through HoU meeting or dedicated Country Offices Risk Committee	Identify & monitor risk metrics against risk appetite	Coming in 2019!
		Submission of Assurance Statements to Regional Bureaux/HQ	

Corporate Level WFP ERM history

2012: 1° WFP ERM Policy – 3 risk categories and 14 corporate risks –

2017: Senior management decides to review ERM policy and risk register versus 2030 agenda

Boston Consulting Group supports new risk register review benchmarking NGO, industry and financial companies registers

2018: RMR Division created – New Risk Register: 4 categories and 15 risks identified

Employees' OSH initially attributed to Operational Risk Category which allows for «risk averse» corporate appetite

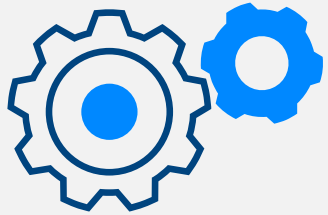
2019 To enforce corporate (in)tolerance for OSH risks to staff, Exec. Mgmt Group reviews Risk appetite for OSH to staff, moving it to the Fiduciary risk category whose appetite statement defines WFP as «highly risk averse». This occurred following the senior management periodic review of the corporate risk register.

New Risk Categorizations

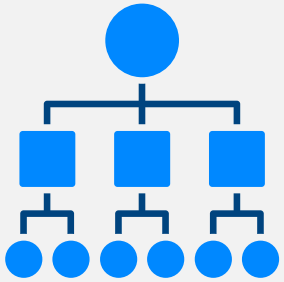
Four design principles guided development of the new risk categories

1. Material
Emphasis on risks with large impact on WFP today or in the future

2. Direct
Risks are captured at the point of impact



3. Actionable
Focus on potential mitigation actions at the programme level, enabling linkage to controls



4. Complete
All risks that fall under principles 1-3 captured for all activities and organisational layers

WFP's Four Risk Categories

Strategic

Impact WFP's ability to achieve strategic goals, objectives and plans

Risk Appetite: potentially risk hungry

Operational

Relate to the implementation and execution of WFP's activities

Risk Appetite: risk averse

Fiduciary

Relate to obligations, including policies, ethical standards and conduct by WFP and its partners

Risk Appetite: highly risk averse

Financial

Impact WFP's financial resources including efficient use of resources

Risk Appetite: risk averse

Risk Categorization

Four risk categories, 15 risk areas and 41 risk types

1. Strategic

1.1 Programme
- 1.1.1 Intervention misaligned with outcome
- 1.1.2 Skill shortage/ mismatch
- 1.1.3 Funding insufficient

1.2 External relationship
- 1.2.1 Restrictive donor funding
- 1.2.2 Misalignment with UN system, governments, partners and non-state actors
- 1.2.3 Disinformation

1.3 Context
- 1.3.1 Conflict
- 1.3.2 Natural disaster
- 1.3.3 Economic crisis

1.4 Business model
- 1.4.1 Failure to innovate
- 1.4.2 Weak/poor execution

2. Operational

2.1 Beneficiary Health, Safety and Security
- 2.1.1 Poor assistance quality
- 2.1.2 Lack of protection

2.2 Partners and Vendors
- 2.2.1 Inadequate availability or capacity
- 2.2.2 Poor/inconsistent quality
- 2.2.3 Inability to safeguard own security

2.3 Assets
- 2.3.1 Theft/deliberate harm
- 2.3.2 Accident

2.4 IT and Communications
- 2.4.1 Utility outage/ disruption
- 2.4.2 System failure
- 2.4.3 Cyber attack

2.5 Business Process
- 2.5.1 Supply chain disruption
- 2.5.2 Mistimed scale-up/down
- 2.5.3 Disruption from change programmes

2.6 Governance and Oversight
- 2.6.1 Poor decision-making processes/quality
- 2.6.2 Inadequate monitoring, reporting and escalation
- 2.6.3 Lack of accountability

3. Fiduciary

3.1 Employee Health, Safety and Security
- **3.1.1 Inadequate occupational health or psychosocial well-being**
- **3.1.2 Poor safety**
- **3.1.3 Insufficient security**

3.2 Breach of Obligations
- 3.2.1 Policies and standards
- 3.2.2 Regulations or laws
- 3.2.3 Third party contracts
- 3.2.4 Donor agreements

3.3 Fraud and Corruption
- 3.3.1 Corruption
- 3.3.2 Misappropriation-Cash
- 3.3.3 Misappropriation-Other Assets
- 3.3.4 Fraudulent reports

4. Financial

4.1 Price Volatility

4.2 Assets and Investments
- 4.2.1 Misutilisation of assets
- 4.2.2 Investment loss

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Risk Ranking

Risks are scored based on likelihood and impact to facilitate prioritisation of mitigation actions and CO resources required to manage the risk

- The likelihood (possibility/ probability) of the occurrence of the risk
- The impact (consequences) of the occurred event on WFP's objectives

Risk Seriousness = Likelihood X Impact

A risk may have a major impact when it occurs, but the likelihood of it happening may be very remote

Conversely, a risk with a rather minor impact may turn into a major risk for the organization if it occurs repeatedly.

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Impact Scale

Score	Impact	Strategic		Operational	Fiduciary			Financial
		Programme/ External Relationships	Contextual	Operational continuity	Health, safety and security	Legal/ Regulatory	Fraud and Corruption	Deficit/ loss
1	Negligible	Negligible or no delay to outcome and impact delivery	Heightened food assistance needs and cluster-lead responsibilities can be addressed through minimal additional investment in ongoing operations. National response capabilities and those of in-country stakeholders are easily able to address the situation.	Negligible or no disruptions- WFP is still able to carry out its operations, with almost no delays or materiel losses. Minimal or no impact on assets.	No or slight harm/ stress	Negligible or no investigation/ key policy breaches/ litigation	Minimal one-off media coverage	No deficit/ loss
2	Minor	Minor delay to outcome and impact delivery	Heightened food assistance needs and cluster-lead responsibilities can be addressed through minor additional investment in ongoing operations. National response capabilities and those of in-country stakeholders are able to address the situation.	Minor disruptions-WFP is still able to carry out its operations, though with some delays or materiel losses. Minor impact on assets.	Non-life threatening harm/ high stress/ slightly injurious effect	Minor or very short term investigation/ key policy breaches/ litigation	Local media coverage lasting less than a month	Deficit/losses <5% of planned budget
3	Moderate	Impact on programme not sustainable over time	Additional resources and activities within ongoing operations and cluster-lead responsibilities will be required to attend to system disruptions and heightened humanitarian needs. National response capabilities and those of in-country stakeholders are are able to address the situation, but may need some support.	Disruptions leading to delays requiring re-planning of operational activities - Programme delivery may be hampered. Some impact on assets.	Serious harm; kidnapping/ injurious and/or Psychologically traumatic effect	Moderate/ short term investigation/ key policy breaches/ litigation	National media coverage	Deficit/loss 5%-25% of planned budget
4	Severe	Failure to achieve programme outcome and impact targets	Substantial additional resources and activities within ongoing operations and cluster-lead responsibilities will be required to attend to system disruptions and heightened humanitarian needs. National response capabilities and those of in-country stakeholders are unable to address the situation without some support.	Disruptions leading to short to medium term suspension of activities. Programme delivery will be significantly hampered. Considerable impact on assets.	Severely Injurious or severely psychologically traumatic effect, there may be a limited number of fatalities	Serious investigation/ key policy breaches/ litigation	International media coverage / donor withdrawal	Deficit/loss 25%-50% of planned budget
5	Critical	WFP risks being unable to function, WFP actions may worsen the situation	Large scale corporate WFP response is required. National response capabilities and those of in-country stakeholders are unable to address the situation without large scale support.	Disruptions leading to long term suspension or cancellation of programmes. All WFP activities may be blocked. Critical impact on assets.	Life loss at scale (mass casualty event)	Prolonged or serious investigation/ key policy breaches/ litigation, severe adverse judgement	Public censure forces shutdown	Deficit/loss >50% of planned budget

Likelihood Scale

Score	Likelihood	Historic occurrence	Forward looking
1	**Very unlikely**	Never	Very unlikely to happen in the foreseeable future
2	**Unlikely**	Once in the last 5-10 years	Unlikely to happen in the foreseeable future
3	**Moderately likely**	Once in the last 2-4 years	Likely to happen in the next 2-4 years
4	**Likely**	One or more times in last 12 months	Likely to happen in the next 12-24 months
5	**Very likely**	On a regular basis over the last 6 months	Likely to occur in the next 6 months

Seriousness Heat Map

Seriousness Score	Seriousness Ranking
1-6	Low Seriousness
7-12	Moderate Seriousness
13-20	High Seriousness
21-25	Very High Seriousness

Risk escalation?

Risk escalation?

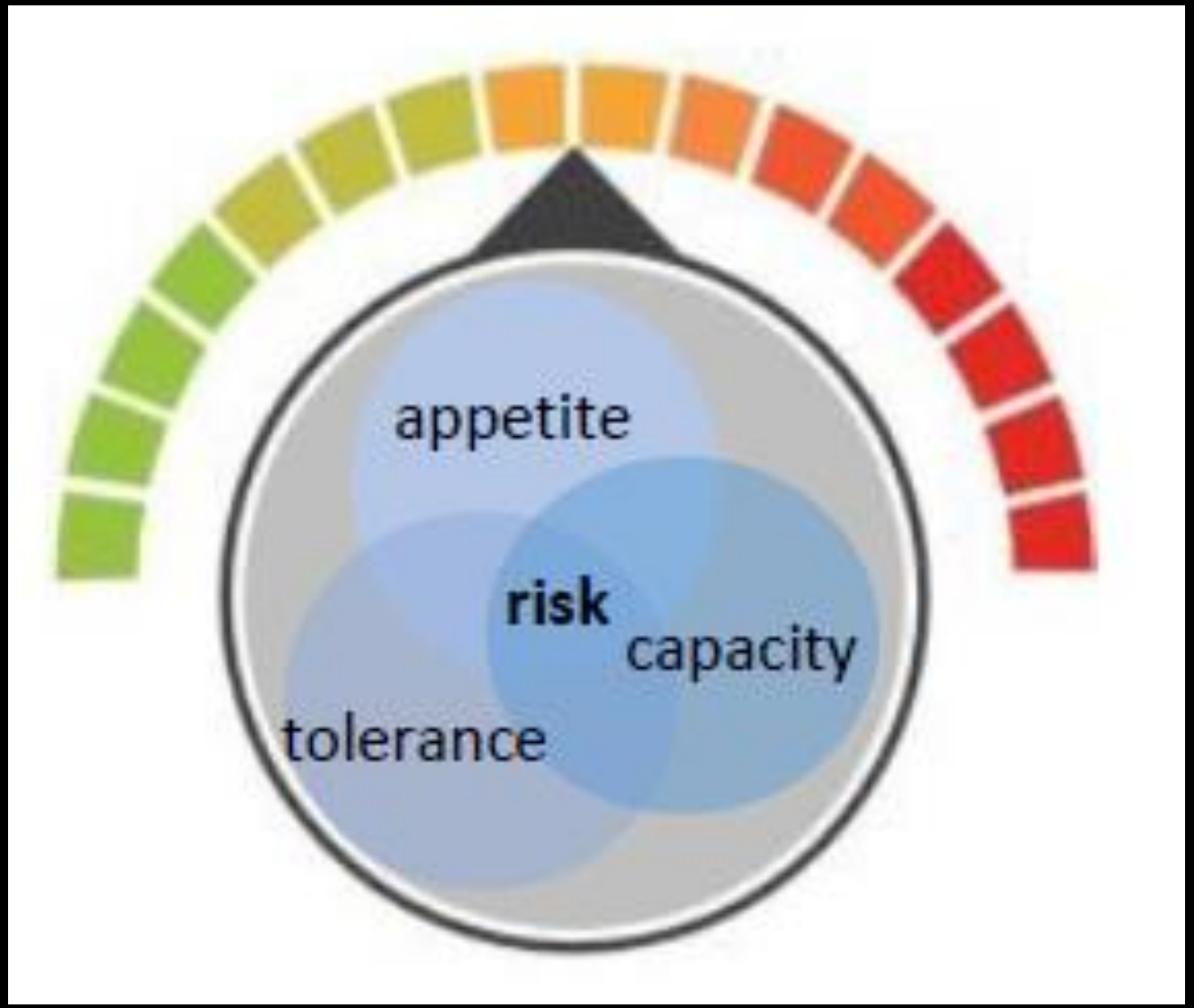
Risk escalation?

5. Critical	5 Low	10 Moderate	15 High	20 High	25 Very High
4. Severe	4 Low	8 Moderate	12 Moderate	15 High	20 High
3. Moderate	3 Low	6 Low	9 Moderate	12 Moderate	15 High
2. Minor	2 Low	4 Low	6 Low	8 Moderate	10 Moderate
1. Negligible	1 Low	2 Low	3 Low	4 Low	5 Low
Impact / Likelihood	1. Very Unlikely	2. Unlikely	3. Moderately Likely	4. Likely	5. Verly likely

OSH Risk Review
Risk appetite statement
Risk performance indicators

Risk Review

- The process of continuous monitoring across Cos/RBs/HQ brings risk management to life
- Supporting management in taking more informed operational and financial decisions
- Allows an essential feed-back loop to reassess mitigating/ preventative actions and escalation as required



Risk Appetite statement: OSH

3.1 Employee Health, Safety and Security
3.1.1 Inadequate occupational health or psychosocial well-being
3.1.2 Poor safety
3.1.3 Insufficient security

Fiduciary risks

3.1 Employee health, safety and security	WFP will assess employee health, safety and security risks in the context of programme criticality and its duty of care. In the event of a critical incident, WFP will take action in line with the United Nations security framework and revise procedures accordingly.

ERM – WFP HQ Risk performance indicators and thresholds

RISK LEAD	STATEMENTS 2018	RISK METRICS/KEY PERFORMANCE INDICATORS - PROPOSED REVISION/ACTIONS	Threshold/parameters	Dates/Data	Responsible	Collected (timing)	Collection (Method)	Escalation (when, how, who is responsible)	Escalation (to whom)
Christophe Boutonnier (RMQ); Sergio Arena (RMW)	WFP will assess employee health, safety and security risks in the context of programme criticality and its duty of care. In the event of a critical incident, WFP will take action in line with the UN security framework and revise procedures accordingly.	i) # of new service incurred long-term disability	Green: 2 Amber: 3 Red: 5	2016 = 1 2017 = 0 2018 = 1 (2 in pipeline)	Enza Alonzi	Quarterly due to low number of cases	Electronic reports (digital Cority platform) on demand of data	Amber: who? Red: CMO to notify risk Lead (RMW Dir.)	Amber: CMO Red RMW Dir.
		ii) % compliance with Field Security Accountability Framework (CRF)	CRF						
		iii) # of new service incurred injuries and illnesses	Green: 20 Amber: 30 Red: 50	(revised figures provided during the meeting): 2016 = 28 2017 = 32 2018 = 22 (9 in pipeline)	Enza Alonzi	Quarterly due to low number of cases	Electronic reports (digital Cority platform) on demand of data	Amber: who? Red: CMO to notify risk Lead (RMW Dir.)	Amber: CMO Red RMW Dir.
		iv) # of medivacs by air ambulance - national v internationals staff.	Green: < 10, Int > Nat Amber: <15, Nat > Int Red: > 15	Data provided in a separate spreadsheet	Alessio Martinelli	Quarterly due to low number of cases	Electronic reports (digital Cority platform) on demand of data	Amber: who? Red: CMO to notify risk Lead (RMW Dir.)	Amber: CMO Red RMW Dir.

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ERM – WFP Regional Office South Africa

Functional area(s)	Existing Measures & Controls in place	New Mitigation Action	Risk Mitigation Action Owner(s)	Status
Staff Counsellor; Management	Implementation of Wellness Strategic Plan 2015 – 2019 and of WFP 2016 Policy on Occupational Safety and Health (OSH) to mitigate work related stress, injuries and illnesses.	• Psychosocial Preparation to hardship duty stations (L3, D, and E), • Employees' access to Health Risk Awareness programmes in the workplace, • Leveraging psychosocial risk-assessment to all duty stations, • Psychological First Aid to Critical Incidents, • Accommodation Standards in the field SOP incidents prevention and reporting Medevacs. • Access to counselling services driver training before Q4, • fire extinguishers serviced every 3 months, • evacuation procedures/drills and staff counsellor inclusion.	Regional Staff Counsellor Deputy Regional Director Regional Director;	All the mitigation actions are in place and they are ongoing.

ERM – WFP Country Office samples

Country	Category	Risk Area	Risk Type	Risk Description	CSP Strategic Outcome	Likelihood	Impact	Seriousness	Org Level	Functional area(s)	Existing Measures & Controls in place	New Mitigation Actions	Risk Mitigation Action Owner(s)
Afghanistan	Fiduciary	Employee_Health_Safety_and_Security	Inadequate occupational health or psychosocial well-being	Lack of specialized medical facilities, including delays in medical evacuation, in particular affecting AOs	ALL SOs	5	5	25	Country Office	Management, Human Resources, Administration	Weekly visit of the UNDSS stress counsellor	1. RB to advise CO on recommendations from May/June 2018 medical assessment mission 2. CO to sign agreement with additional health sector providers 3. CO to organize regular information sessions on staff entitlements 4. CO to explore options to reduce costs of medical evacuation in AOs	Head of HR (in coordination with RBB&HQs medical officers)
Afghanistan	Fiduciary	Employee_Health_Safety_and_Security	Inadequate occupational health or psychosocial well-being	Delay in move to UNOCA and without adequate security and wellness measures in place in UNOCA could have an impact on staff well-being and increase exposure to security risks.	ALL SOs	3	5	15	Country Office	Management, Human Resources, Administration, Security, Supply Chain - Procurement	1. For staff wellness, there are many gyms, yoga classes, salsa classes and playgrounds are in place. 2. UN games are conducted in UNOCA compound. 3. High security system/measures are in place.	Development of comprehensive translocation plan (including staff wellness and security) related to the move to UNOCA	DCD for Support Services (with support from Heads of ADM/Security/ HR)
Chad	Fiduciary	Employee_Health_Safety_and_Security	Inadequate occupational health or psychosocial well-being	Lack of adequate medical and wellness facilities in field office locations	ALL	5	3	15	Country Office	Human Resources	1. Plan to re-assess medical facilities in all field locations 2. Ensure regional staff counsellor and wellness missions to field locations 3. Ensure visits to field locations by UN staff counsellor in N'Djamena	Head of HR	N

ERM – WFP Country Office samples

Country	Category	Risk Area	Risk Type	Risk Description	CSP Strategic Outcome	Likelihood	Impact	Seriousness	Org Level	Functional area(s)	Existing Measures & Controls in place	New Mitigation Actions	Owner(s)
Nigeria	Fiduciary	Employee Health, Safety and Security	Inadequate occupational health or psychosocial well-being	Lack of medical facilitities in Damaturu and Hubs, poor enforcement of appropriate work-life balance, and challenging living conditions in Hubs undermining staff wellness.	SO1 SO2 SO3 SO4 SO5 SO6	5	2	10	Country office	HR Management	1. Ensuring appropriate ergonomics support is provided through HQ support 2. Facilitate viists to Damaturu field office by UN Doctor 3. Engage managment on measures to ensure appropriate work-life balance 4. Establish staff wellness committees	HR Wellness	N
Kenya	Fiduciary	Employee_Health_Safety_and_Security	Inadequate occupational health or psychosocial well-being	High anxiety and stress levels in staff due to organizational realignment	ALL	5	2	10	Country Office	Management Human Resources		Head of HR DCD Operations	N
Eswatini	Fiduciary	Employee_Health_Safety_and_Security	Inadequate occupational health or psychosocial well-being	Over reliance on short term contractual arrangements for staff, reliance on UNDP roles and procedures for the review of SSC salary scales and uncertainty over long term outlook for CO undermining staff psychosocial welfare.	SO1 SO2	4	2	8	Country Office	Human Resources	1. Mission from RBJ HR Officer to support organisational realignment scheduled for May 2. CO to review SC salary scales based on 2018 fixed term salary survey results	Human Resources Officer	N

World Food Programme

Additional initiatives
Where to go next?

Some additional initiatives taken to integrate OSH risk management in WFP

- ✓ Establishment of a WFP Wellness Vision: *"WFP is dedicated to promoting and maintaining the highest degree of physical, mental and social wellbeing of all employees. Accordingly, it seeks to offer a safe and healthy working environment which contributes to human dignity and self-fulfillment."*
- ✓ Promulgation of the WFP Occupational Safety and Health Policy
- ✓ Promulgation of a WFP Wellness Strategy
- ✓ Periodic dissemination of Wellness Survey to gain insights from all personnel on their OSH issues and needs, which feeds into risk register and Country Wellness Plans
- ✓ Establishment of central, regional and country Wellness Steering Committees
- ✓ Availability of loans and grants centrally managed by the Wellness Division to support Country Wellness Plans
- ✓ Integration of OSH into the accountability framework for WFP country directors

WFP World Food Programme

Where to go next?

- Under-reporting of service incurred injuries and illnesses: improve data collection
- Address risk treatment for national staff
- Monitoring to be improved together with ERM socialisation
- Key Performance Indicators only developed at the global level and need to be established at regional and country levels
- Country risk registers to be periodically reviewed against Wellness Plans
- Update Code of Conduct with OSH elements

WFP World Food Programme


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Questions?

Managing risks related to Occupational Safety and Health (OSH)

A Case Study

UNHCR

UNHCR
The UN Refugee Agency

Purpose of this document

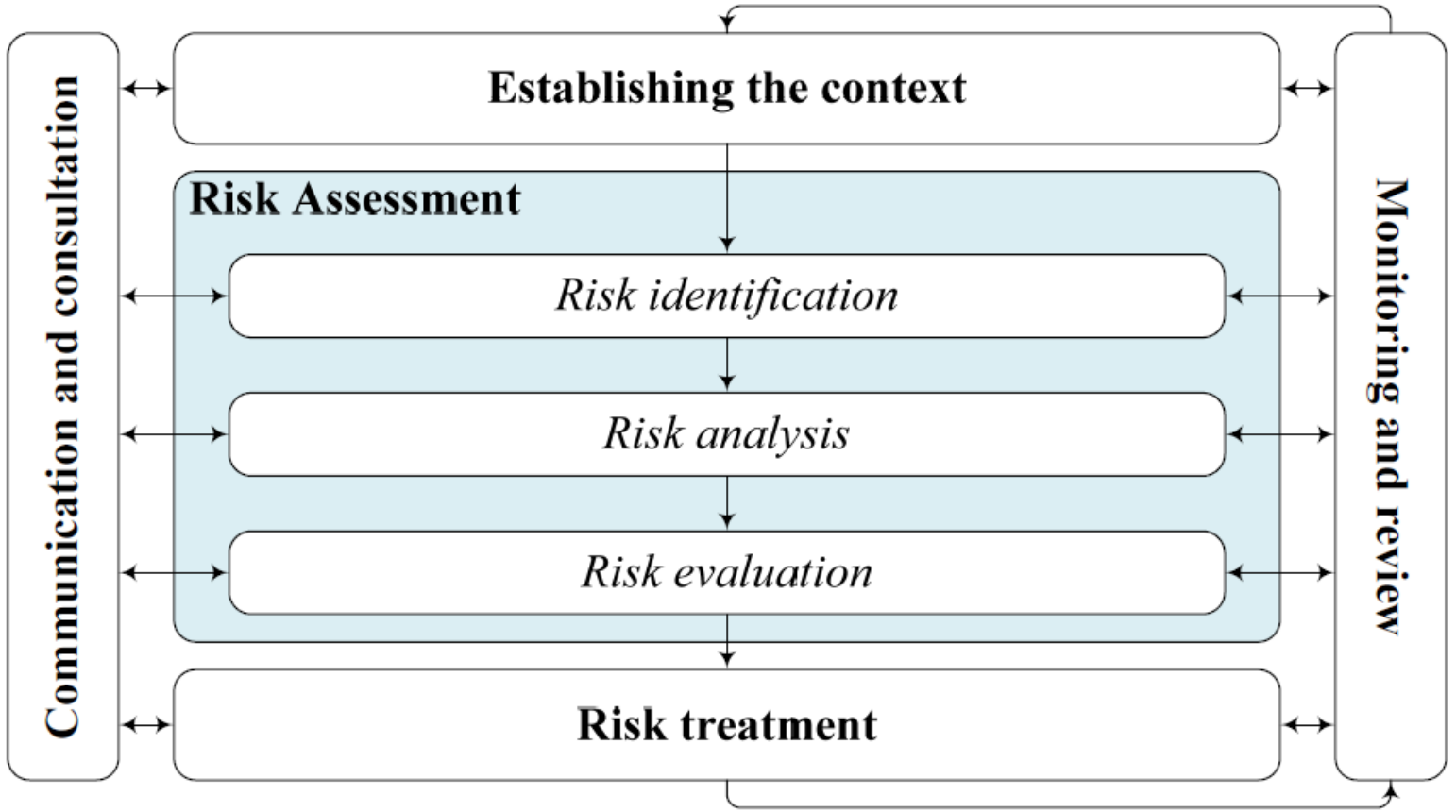
- This document describes the overall Enterprise Risk Management (ERM) process in UNHCR and how Occupational Safety and Health (OSH) risks are currently captured as part of this.

- The document is intended as an example of one of many possible ways in which a UN organization can manage risks – it is not intended to be prescriptive.

The risk management process

- The UNHCR policy on Enterprise Risk Management is based on the ISO31000 standard

- This chart schematically represents the risk management process in UNHCR as per ISO31000



The risk management process

Top down and bottom up

- Risks in UNHCR are managed in accordance with this policy and process
- The process is applied in top down manner in relation to organization wide risks
- The process is also applied in a bottom up manner in relation to risks in every field operation or Headquarters entity
- It should be noted that ERM in UNCHR is relatively high level and strategic (the average number of risks in a field operation as of April 2019 was 14)
- In some functional areas operations conduct more detailed risk assessments which are not managed and reported on through the ERM procedures

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Top-down risk management process

Strategic Risk Register

- Owned by the High Commissioner
- Captures strategic, cross-cutting organization-wide risks

- Currently contains 16 risks
- Includes one risk focused on the organization's ability to provide adequate occupational health and safety to its personnel
- Treatments for this risk will be primarily implemented by the Division for Human Resources
- Progress against treatments will be monitored and periodically reported to senior management by the Enterprise Risk Management Unit

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Top-down risk management process

Sources of risk information

In identifying strategic risks, the following sources of information were considered to develop an initial list that was reviewed and revised by the UNHCR Senior Executive Team:

- The outputs of the bottom-up risk management process
- Discussion points from the Global Representatives meeting
- Analysis of Internal Audit, Evaluation and other oversight reports
- Review of financial and performance data
- Review of key organizational processes
- Strategic objectives and the views of senior management
- Concerns raised by Member States and donors

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Bottom-up risk management process

2,204 risks captured, 144 of these risks related to OSH and security including:

- Preventing and responding to sexual harassment and other abuses of authority
- Staff burnout and vicarious trauma
- Road safety; and
- Medical facilitates and evacuations

- Every field operation and HQ entity has its own risk register (over 160 in total)
- Results collected in a combined Corporate Risk Register

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Bottom-up risk management process

Sources of risk information

In identifying country level risks, field operations typically consider the following sources of information (*amongst others*)

- The outputs of the Strategic Risk Register
- The operation's and region's strategic objectives and priorities
- The operational context (political, economic social, technological, legal, environmental, security, etc.)
- Needs assessments of persons of concern
- Results of previous oversight reports or missions from HQ
- *Sector specific guidance*

Uses of risk information

In Headquarters only

- Analyze and monitor trends from the field
- Consider risk information in policy setting, resource allocation and monitoring and oversight

- Prioritize management attention
- Identify, analyse, respond to and monitor risks effective and consistently

In the field and Headquarters

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Next Steps

Strengthening OSH risk management in UNHCR

- **Enhance reporting:** UNHCR uses 37 distinct sub-categories of risk– however, there is not a dedicated one for OSH, with most relevant risks captured under the categories *Human Resources, Security and Staff Safety.* UNHCR is exploring ways to improve reporting and analysis of OSH risks such as allowing users to tag these risks across multiple categories or by revising the categories themselves.
- **Improve the identification and assessment of OSH risks:** Where sector specific guidance on typical risks and appropriate responses exists (such as in cash-based interventions, fraud, and partnership management) the quality of risk assessments tends to improve. In collaboration with the HLCM Duty of Care Task Force, UNHCR is considering to initially focus on three related themes – living conditions/accommodations, road safety and Mandatory Health Support Elements - to assist field operations in identifying and responding to risks associated with Occupational Safety and Health (OSH).

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Next Steps

Establishing risk appetite and tolerance

- **Risk appetite:** UNHCR will soon begin developing a risk appetite statement. This will clarify the level of different risks senior management is willing to accept in pursuit different objectives. The statement should make this more explicit and practically guide operational managers in decision making. The same concept is currently applied in Programme Criticality but this would cover all risks – not just security and staff safety ones.

- **Risk tolerance:** Linked to this UNHCR will work to establish measurable thresholds that trigger a response when they are breached. For example, a possible hypothetical tolerance level could be along the lines of: *If one or two Mandatory health Support Elements are not in place in a duty station, the matter is automatically referred to senior management for a decision, if three or more are not in place, we automatically suspend operations*.

Appendix 1

Further details on generic risk management processes

Risk analysis

In the UNHCR ERM framework, risks, including OSH ones, are analyzed based on the impact (if they will occur), and the likelihood that they would occur

Analyze Impact

- Insignificant
- Minor
- Moderate
- Major
- Disastrous

How bad could it hurt us?

How likely is the event to happen?

Analyze Likelihood

- Very low
- Low
- Medium
- High
- Very high

Acknowledge and evaluate existing proactive and reactive risk treatments

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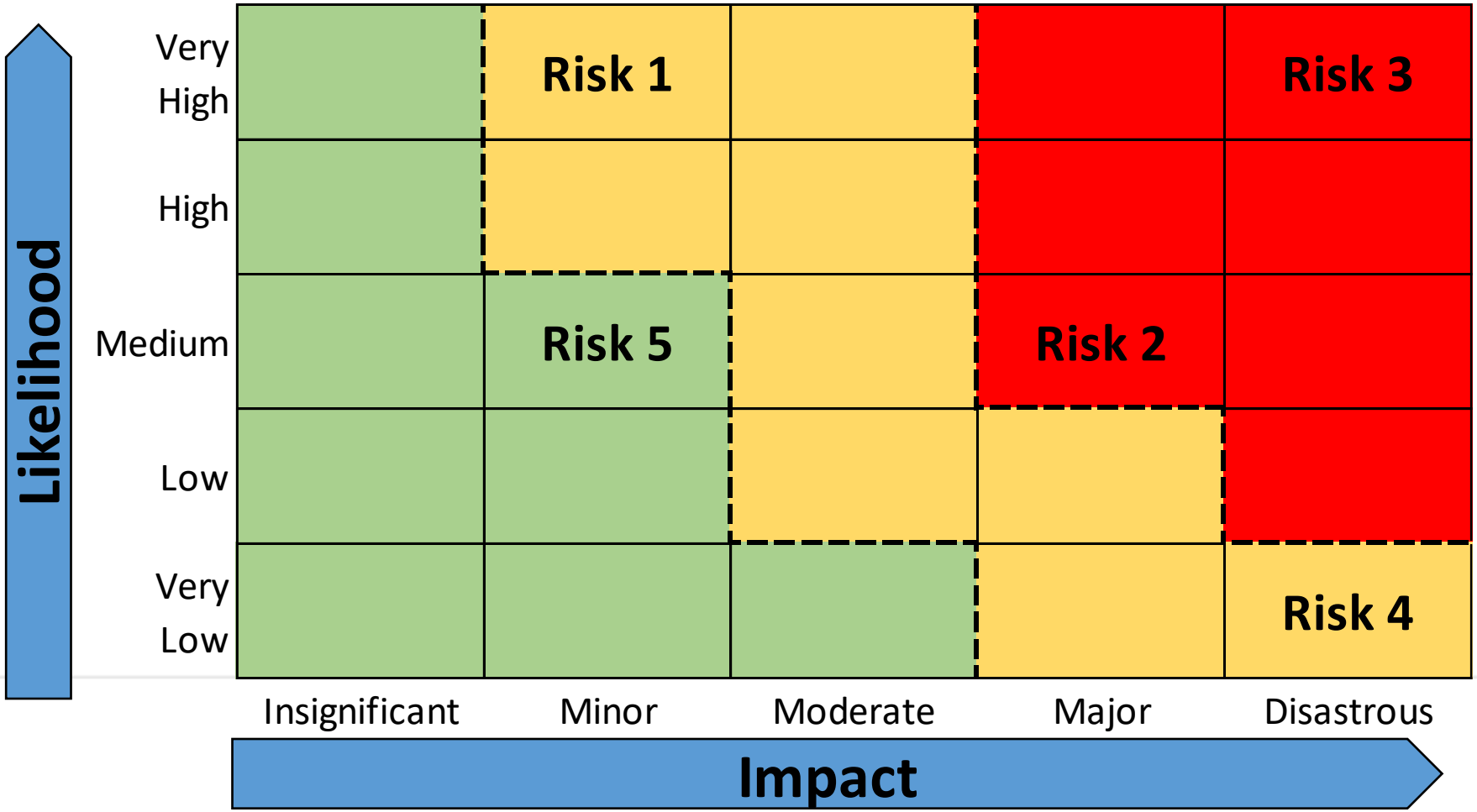
Likelihood – impact grid

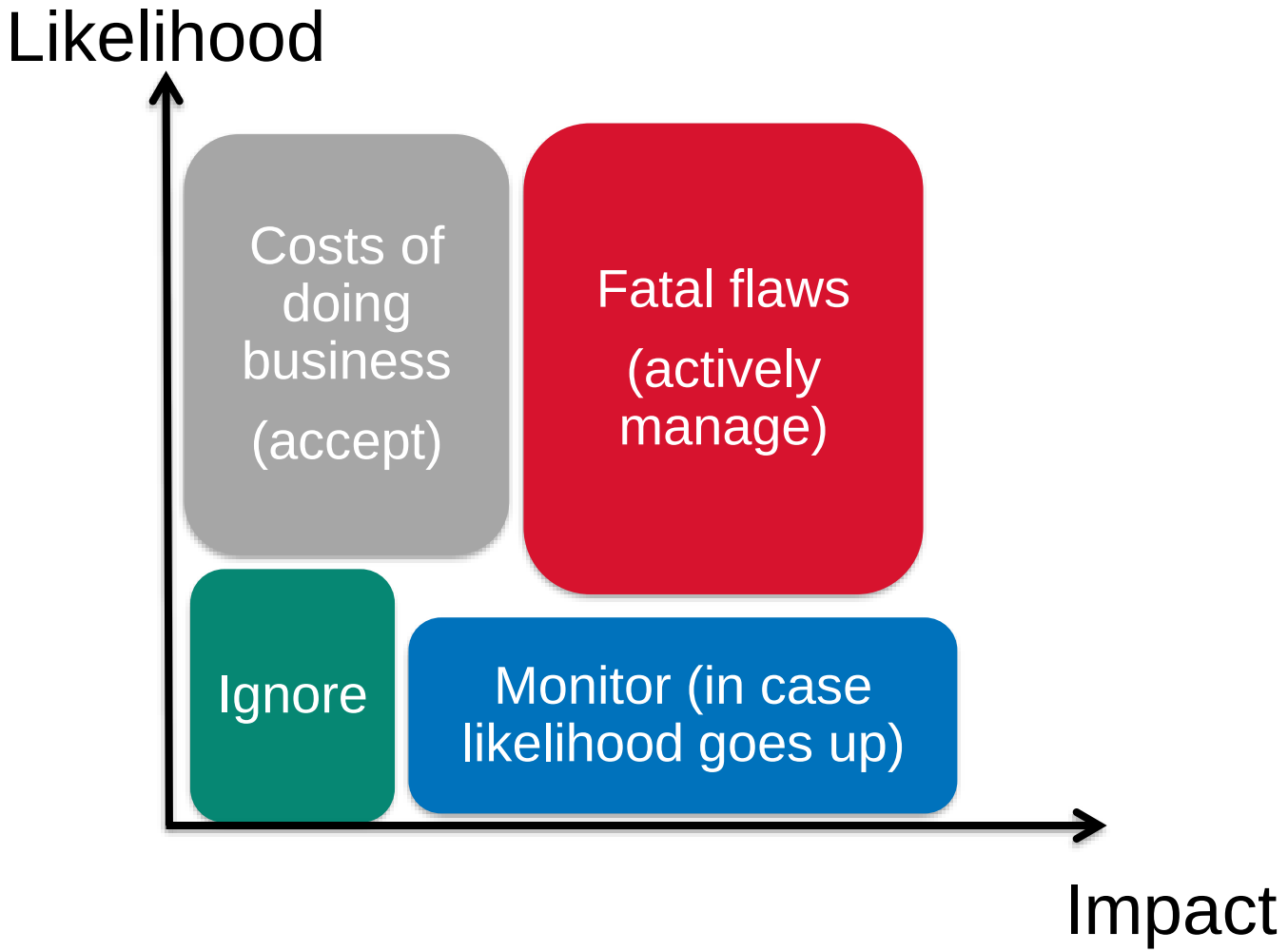
These risks are captured in an online tool and visualized on a likelihood – impact grid to aid prioritization



Likelihood – impact for decision making

The likelihood – impact grid can also guide decision making on how to respond to risks.

Although each risk should be assessed on its own merit, the following responses are generally valid for risks in each part of the grid



Risk evaluation

- There are four broad types of response to risk: Tolerate, Treat, Transfer or Terminate
- After evaluating the risk the appropriate response should be selected
- The risks and their responses should be monitored over time to ensure they remain valid

Tolerate
(do nothing)

Treat
(mitigate to reduce likelihood/impact)

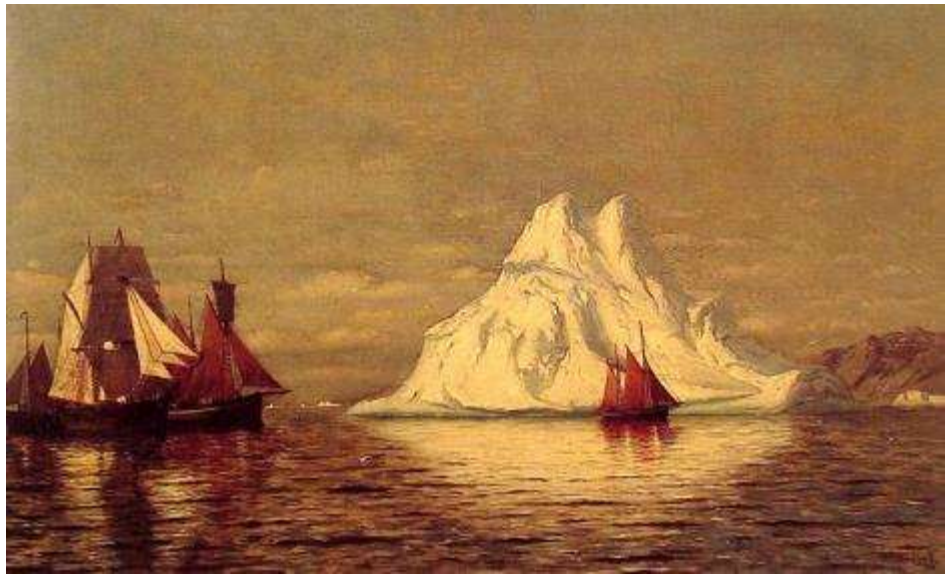
Transfer
(for example through insurance)

Terminate
(stop the activity because it is too risky)

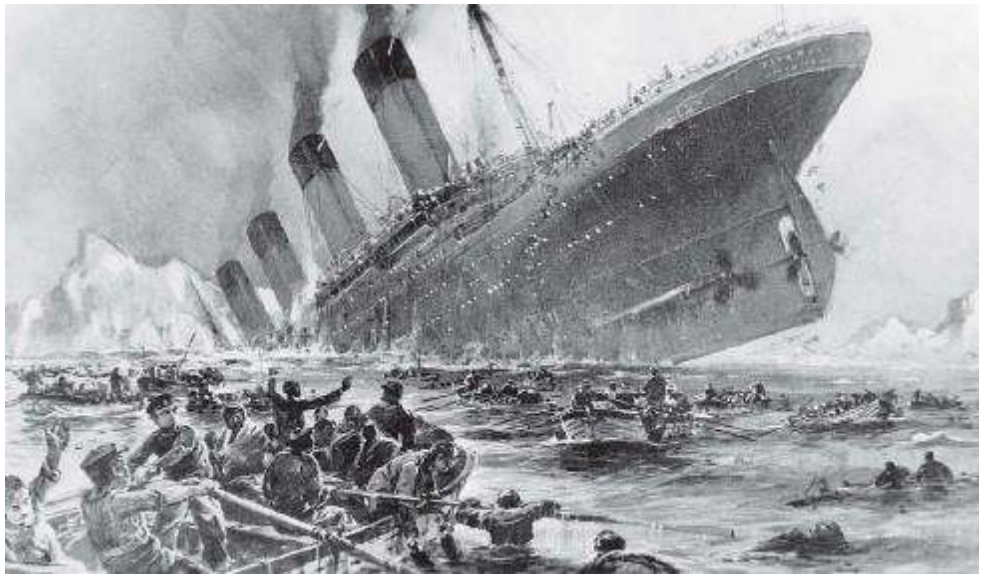
Risk treatments

When treating a risk we can respond proactively (typically to reduce the likelihood of a negative event occurring) or reactively (typically to reduce the negative impact once the risk event has occurred)

Proactive



Reactive



Annex 4. Voluntary Guidelines for Affiliate, Standby and Non-UN Personnel

A. Voluntary Guidelines: Affiliate Personnel

1. Affiliate personnel, for the purposes of this work, refers to individuals with direct contractual relationship with the organizations, including but not limited to consultants, individual contractors, holders of Service Contract, interns, UN volunteers, fellows, UNOPS contractors (e.g. LICAs and IICAs) etc.

Prior to deployment:

Measures to be provided/actions to be taken	Suggested actions by the UN organization	Suggested actions by the affiliate personnel
Provision of detailed information	Share a pre-deployment guide with the individual	Read and acknowledge the pre-deployment guide
	Share a country-specific fact sheet, if available, with the individual	Read and acknowledge the country-specific fact sheet
	Provide key information, if available, for the individual to share with families, including key contacts in the organization and relevant instructions in case the individual is injured or otherwise affected	Read and acknowledge receipt of such information
	Provide standard information on the terms and conditions of the assignment (e.g. tax, insurance, visa etc.)	Read and acknowledge receipt of such information. Seek private advice on such provisions if necessary (e.g. individual's obligations regarding tax, insurance, visa etc.).
	Provide a copy of code of conduct and undertaking to be signed at the beginning of the assignment and inform the individual that the affiliate workforce/non-staff contract does not carry any expectations for being appointed as staff.	Read and acknowledge receipt of such information.
Medical certification	Verify that the individual is medically fit to work in the duty station	Provide the organization with a medical certification (from a licensed medical professional/ health care provider) that he/she is medically fit to work in the capacity contracted and in the specific duty station (as per the guidance set-out in Example 1, Section D). Alternatively, organizations may require that the individual completes a self-certification form.
Security clearance	Verify that the individual has security clearance (from UNDSS) to travel to the duty station, including completion of the mandatory BSAFE, the new online security awareness training, and any other mandatory training that may be required specific to the duty station and/or organization.	Provide the organization with the security clearance as well as the certificate on successful completion of BSAFE and any other requisite training.

Measures to be provided/actions to be taken	Suggested actions by the UN organization	Suggested actions by the affiliate personnel
Secure travel and visa arrangements	Assistance (e.g. official letter or information) where necessary, with immigration and travel documents, including on arrival at the duty station. Any costs related to travel and visa are to be agreed between organization and individual prior to deployment and stated in the agreement.	Unless the contractual agreement specifies otherwise, the responsibility of obtaining the necessary visas and travel arrangements are the responsibility of the individual.
Reasonable accommodation of disability and other special needs	Where relevant, to ensure reasonable accommodation is provided. The Organization will assist the individual with information on any special needs, as applicable.	Unless the contractual agreement specifies otherwise, to make the necessary accommodation arrangements and inform the organization of any special needs.
Certification of appropriate insurance coverage	If the Organization is not providing health insurance: Inform the individual of the requisite insurance requirements; and verify that the individual has the appropriate insurance coverage (see Example 1, Section D)	If health insurance is not provided by organization: To provide proof of health insurance, meeting the minimum requirement (see Example 1, Section D), which is valid for the duration of the assignment.
	Medical evacuation insurance: If not provided by the organization, but required under the terms of the contract, verify that individual has coverage for medical evacuation (see Example 2, Section D)	If not provided by the organization but required under the terms of the contract, must provide proof of medical evacuation insurance (as per Example 2, Section D), which is valid for the duration of the assignment.
	Where appropriate, provide adequate compensation for service incurred injury, illness and death (see Example 3, Section D)	In accordance with the contractual agreement, the individual must comply with all security policies and procedures of the organization and take all necessary measures to avoid putting him/herself in harm's way.
Mutual accountability of the hiring manager, releasing organization (if applicable) and individual on proper preparation	Ensure that expected deliverables, delegated tasks, and supervisory lines are clear to the individual prior to deployment, and for urgent deployment, immediately upon arrival at the duty station.	Ensure expected deliverables and delegated tasks are clear, and reporting lines are known.

During deployment:

Measures to be provided/actions to be taken	Suggested actions by the UN organization	Suggested actions by the affiliate personnel
Inclusion under the security system in place	Include the individual in the safety and security system in the duty station and provide any necessary security equipment	Comply with the instructions of the safety and security team
	Provide additional security measures (e.g. transport from residence to office) as approved by the Security Management Team (SMT).	Comply with SMT's decision(s).
Accommodation, if provided, meets the minimum standards (as approved by HLCM)	If individuals are required to live in accommodation provided by the organization, ensure that the accommodation meets the minimum standard.	Comply with the provisions governing the administration of the organizational-provided accommodation
Network bandwidth	Ensure adequate bandwidth is provided to all personnel in the duty station (as per the requirement approved by HLCM[1]).	Comply with organization's policy on the use of organization's bandwidth (e.g. do not use bandwidth to watch/download inappropriate contents)
Access to medical and psychosocial services, similar to those provided to staff	• Provide access to local medical services offered by the organization (e.g. UN/DPO clinics) and information on other services available at the duty station. • Provide information on mental health services, locally or through remote consultation • Ensure access to first aid/medical essentials	N/A
Compensation commensurate with difficult working conditions	• Remunerate personnel in a manner that takes into account difficult working conditions. • Where applicable, the inclusion of a periodic time-off similar to R&R and well-being differential for internationally recruited personnel and UNVs (in accordance with the relevant agreements).	N/A
Inclusion in trainings and learning opportunities	• Ensure that the individual is provided with the opportunity to undertake all mandatory security and administrative training and learning opportunities as necessary to conduct their official duties. • Ensure that the individual has access to and completes the mandatory and necessary training courses (see Example 4).	Attend and complete all mandatory and relevant training courses.

[1] CEB/2018/HLCM/5/Rev.1, Annex 12.

Measures to be provided/actions to be taken	Suggested actions by the UN organization	Suggested actions by the affiliate personnel
Access to dispute resolution mechanism and protection against sexual harassment, harassment and abuse of authority and retaliation	Inform individuals of their rights to access dispute and other conflict resolution mechanisms (e.g. access to the ombudsman and ethics office, etc.) and the policies with respect to protection against sexual harassment, harassment and abuse of authority and retaliation.	Proactively seek support and inform the organization of cases of harassment, etc. through the appropriate channels. Familiarize themselves with the relevant organization's policies and procedures.
Appropriate on-going support and fair assessment of performance.	Ongoing support is provided to the individual, as needed, and that a fair assessment of performance is ensured.	Proactively participate in the performance management process, as per the organization's policies and procedures.

Post deployment:

Measures to be provided/actions to be taken	Suggested actions by the UN organization	Suggested actions by the affiliate personnel
Certificate of service/ successful performance, if applicable.	• Ensure an appropriate mechanism to trace performance reports and other relevant information/ references. • Establish an appropriate mechanism to track under performers and disciplinary cases to ensure that other UN organization are appropriately informed (e.g. via the Clear Check database) and consider such information in their hiring decisions.	Provide true statement with the application form
Timely settlement of final emoluments as provided in the contract (e.g. last pay, travel costs etc.)	Ensure that all outstanding payments are made within the next payment cycle or at least within 30 days of receipt of all documents.	Comply with all administrative requirements and check out formalities.
Follow-up mechanism/ compensation in case of long-term effects of occupational illnesses/accidents	• When compensation is provided by the organization, ensure that compensation for any occupational illness/accidents is paid within 60 days of receipt of the claim and all documents or as otherwise determined by the legal framework of the organization. • When compensation is provided by an insurance provider retained by the organization, ensure that the insurance contract requires the insurance provider to pay any required compensation within 60 days of receipt of the claim and all documents.	N/A

B. Voluntary Guidelines: Standby Personnel

2. The Standby Partnership (SBP) Network is an informal network of UN organizations and partner organizations, whereby annual consultations are held to review key responses and common issues such as security inclusion and management, monitoring, results-based management, training and induction. The SBP Network Partnership comprises of a range of partners which provide support to UN organizations responding to humanitarian emergencies throughout the world via secondment of standby personnel[2]. Each Standby Partner organization maintains its own roster of humanitarian experts who are called upon to fill staffing needs and gaps in UN operations. The practice in many UN agencies is to obtain a written undertaking from the expert deployee personnel, including to facilitate 'expert on mission' status. The SBP Network has collaborated with the Working Group of the HLCM Task Force to develop the below voluntary guidelines as suggestions for practical implementation.

Prior to deployment:

Measures to be provided/actions to be taken	Suggested actions by the Standby Partners	Suggested actions by the receiving UN organization	Suggested actions by the Standby personnel
Provision of detailed information	Provide and explain the personnel's contract, conditions of service, Code of Conduct, provisions of the Standby Agreement and undertaking applied to the personnel.	Verify that the provisions of the agreement between the receiving and deploying organizations, including Code of Conduct, are understood through receipt of a signed Undertaking. Provide the deploying organization with up-to-date information on conditions of service.	Read and understand the contract, conditions of service, Standby Agreement between the receiving and deploying organizations, Code of Conduct and Undertaking. Sign the contract and Undertaking and provide to the deploying organization.
	Ensure that personnel are provided with the pre-deployment guide of the receiving organization.	Pre-deployment guide is shared with the deploying organization.	Read and acknowledge the pre-deployment guide.
	Country-specific fact sheet is shared with the deploying personnel.	N/A	Read and acknowledge the country-specific fact sheet
	UNDSS Security Advisory, policies and procedures are shared with personnel.	UNDSS Security Advisory, policies and procedures are shared with the deploying organization.	Review and remain alert to UNDSS Security procedures

[2] There are presently 14 UN organizations and more than 45 partner organizations within the SBP. The partner organizations are governmental, non-governmental or private sector companies or foundations. Participating UN organizations include: FAO, IOM, OCHA, UNDP, UNESCO, UNFPA, UN-HABITAT, UNHCR, UNICEF, UNMAS, UNRWA, UN Women, WHO and WFP.

Measures to be provided/actions to be taken	Suggested actions by the Standby Partners	Suggested actions by the receiving UN organization	Suggested actions by the Standby personnel
	Available information on access to medical facilities and available accommodation are shared with the deploying personnel prior to deployment.	Available information on access to medical facilities and available accommodation are shared with the deploying organization.	Review available information on access to medical facilities and available accommodation prior to deployment.
Medical certificate	Verify that the individual is medically fit to work in the duty station and provides all necessary information on vaccinations required (see Example 1).	Verify that the medical clearance is complete through receipt of the medical certification.	Provide their deploying organization with a medical certification (from a licensed medical professional) that he/she is fit to work in the duty station and all requisite vaccinations have been obtained.
Security clearance	Inform personnel to undertake mandatory UNDSS security training/s. Ensure that personnel have completed all mandatory training, obtained the necessary certificates and applied for the necessary security clearance.	Provide information to the deploying organization on how to obtain security clearance for personnel and access mandatory trainings courses.	Apply for security clearance through UNDSS TRIP platform prior to travel to the duty station. Complete and provide the deploying organization the necessary trainings certificate/s and security clearance.
Secure travel and visa arrangements	Ensure that the deploying personnel has a visa to legally work in the country of deployment.	Provide assistance as applicable for the visa process.	Complete the required pre-deployment visa process.
Certification of appropriate insurance coverage	Provide, or verify that the personnel have the necessary health insurance (see Example 1)	Health insurance coverage for the deployed personnel must be dealt with in the MOU between the deploying organisation and the receiving organization	If not provided by the deploying organization, the individual must provide proof of health insurance, meeting the minimum requirement, and evidence that the insurance is valid for the duration of the assignment.
	Where necessary, provide, or verify that the personnel have adequate coverage for medical evacuation (see Example 2)	Where required, medical insurance/evacuation arrangement must be dealt with in the MOU between the deploying organization and the receiving organization	If not provided by the deploying organization directly, deployed personnel must provide proof of medical evacuation insurance, meeting the minimum requirement, and evidence that the insurance is valid for the duration of the assignment.
	Provide adequate compensation for service incurred injury, illness and death (see Example 3)	Arrangements for occupational injury, illness and death insurance must be dealt with in the MOU between the deploying	If not provided by the deploying organization directly, deployed personnel must provide proof of occupational injury, illness and death

Measures to be provided/actions to be taken	Suggested actions by the Standby Partners	Suggested actions by the receiving UN organization	Suggested actions by the Standby personnel
		organization and the receiving organization	insurance, meeting the minimum requirement, and evidence that the insurance is valid for the duration of the assignment. Must comply with the policy, procedure and process of the receiving organization. Must take all necessary measures to avoid putting him/herself in harm's way.
Clear assignment of roles and responsibilities	Ensure expected deliverables, delegated tasks and reporting lines are clear to the deploying personnel prior to or upon arrival (for urgent deployments).	Prior to deployment, provide a Request form, ToR and/or in country briefing to set expected deliverables and delegated tasks as well as reporting lines.	Review expected deliverables and delegated tasks, ensure reporting lines are known prior to deployment. In the cases of rapid deployment, at latest one week after arrival to the duty station.

During deployment:

Measures to be provided/actions to be taken	Suggested actions by the Standby Partner	Suggested actions by the receiving UN organization	Suggested actions by the Standby personnel
Ongoing dissemination of security/medical and other relevant information	Provide relevant proof of employment as may be required for visa/ registration purposes in country of deployment.	Provide a valid form of UN identification.	
	Consider and approve changes to the duty station as/when needed.	Should there be a need for change of duty station, request the change in writing to the deploying organization.	Consult with deploying organization on any change of duty station.
	Verify that the deployed personnel are included in the safety and security system and provided with briefings in the duty station	Where applicable, include the personnel in the safety and security system and briefings in the duty station, provide any necessary security equipment	Comply with the instructions of the safety and security team
	Ensure that deployed personnel are made aware of all mandatory trainings which need to have been completed on arrival	Ensure that the personnel are provided with all mandatory training in the duty station, if applicable, prior to deployment.	Attend and complete all mandatory training courses as required by the organization.

Measures to be provided/actions to be taken	Suggested actions by the Standby Partner	Suggested actions by the receiving UN organization	Suggested actions by the Standby personnel
Application of minimum standards for accommodation	N/A	If due to security, personnel must stay in an organization's provided accommodation or a set list of approved locations, the accommodation must meet the minimum standards as approved by HLCM[3].	Comply with approved accommodation policies.
Inclusion under the security system in place	N/A	If due to security, transport is provided between home and office locations, provide the same for deployed personnel.	Comply with approved transport policies.
	N/A	Ensure all personnel are copied on distribution lists for security information and are part of any alert system/communication trees/radio protocols.	Comply with the necessary alert system/communication trees/radio protocols.
	To inform its personnel of the protocols for security incidents, such as hostage taking, arrest and detention are in place. Maintain 24-hour emergency contact details for the receiving agencies.	Ensure deployed personnel are reflected in protocols for security incidents such as hostage taking, arrest and detention, define the required cooperation/ communication with the deploying organization in the event of an incident. Maintain 24-hour emergency contact details for the deploying organizations.	N/A
	Ensure the deployed personnel have clear communication and support channels to report any security concerns and/or incidents.	Ensure that security concerns/incidents involving deployed personnel are reported and responded to through the same channels as staff, and that the deploying organization is informed.	Ensure to report security concerns and incidents immediately.

[3] CEB/2018/HLCM/5/Rev.1, Annex 11.

Measures to be provided/actions to be taken	Suggested actions by the Standby Partner	Suggested actions by the receiving UN organization	Suggested actions by the Standby personnel
Adequate bandwidth	N/A	Access to adequate bandwidth for personal and telehealth services	Comply with the organization's policy on the use of bandwidth or ICT equipment (e.g. do not use bandwidth to watch/download inappropriate contents, etc.)
Access to available medical and psychosocial services.	Ensure deployed personnel are informed about access to the medical facilities, where applicable.	Ensure that deployed personnel have the same access as staff to any UN specific medical facilities and are included in medevac planning.	N/A
Compensation commensurate with the work and working conditions	N/A	Personnel should be able to exercise leave and other entitlements as stipulated in their agreements/contracts.	Follow the procedures accordingly.
Terms in the contractual agreement describe the mechanism for dispute resolution.	Ensure deployed personnel are aware of dispute resolution mechanisms and reporting channels (including for PSEA) available through the deploying organization.	Inform deployed personnel of their access to procedures concerning prohibited conduct such as SEA, harassment, retaliation, as well as access to the ombudsman, ethics, peer support, welfare officers, and IGO.	Ensure awareness of reporting regulations of both deploying organizations and receiving organization.

Post Deployment:

Measures to be provided/actions to be taken	Suggested actions by the Standby Partner	Suggested actions by the receiving UN organization	Suggested actions by the Standby personnel
Follow-up mechanism/ compensation in case of long-term effects of occupational illnesses/ accidents.	Provide referrals and availability of psychosocial care and support.	N/A	Comply with any mandatory psychosocial support services in place through the deploying organization.
Development and implementation of a mechanism to collect and reflect on the	Conduct debriefing within two weeks upon return of the staff	Where possible, undertake an exit interview with departing personnel and ensure necessary feedback is recorded	Complete the exit interview before the last day with the deploying organization, and undertake a debrief within two weeks upon return with deploying organization

Measures to be provided/actions to be taken	Suggested actions by the Standby Partner	Suggested actions by the receiving UN organization	Suggested actions by the Standby personnel
feedback from the personnel	Ensure deployed personnel are provided with a copy of the Performance Evaluation Report template. Request and record completed Performance Evaluation Reports for roster members.	Ensure regular performance follow up is undertaken and the Performance Evaluation Report is completed by the agreed supervisor or alternate and recorded for future confirmation of performance. This will be shared with the deploying organization.	Ensure Performance Evaluation Reports are completed prior to leaving duty station including final comments and agreement with ratings.

C. Voluntary Guidelines: Non-UN Personnel

1. UN organizations engage implementing partners (IP), to implement UN projects on the ground, or third-party contractors (TPC), which are typically for-profit organizations whose personnel perform services under a contract between the third-party contractor and the UN organization. These partners and contractors in turn contract personnel directly, many of whom work in high-risk locations, in particular in areas where the entry of UN personnel is strictly limited under the UN Security Management System (SMS), and contribute greatly to the delivery of UN's mandate in those locations. As such, they can be perceived by the public, media and all stakeholders as part of the UN organization to which they are deployed.

2. These individuals do not have a contract or a direct employment relationship with any UN organization. The contracting UN organizations conclude contracts only with the employing TPCs and IPs (hereafter "contractors").

3. While the UN organizations do not have legal liabilities towards or direct relationship with these personnel, due to their high-risk location and visibility, there is a strong imperative for UN organizations to require that the contractors and partners ensure certain standards in relation to their employees. The enunciation of these standards and best practices serves to ensure that partners and contractors are aware of and ready to comply with the minimum standards expected when working with UN organizations.

4. As an example of a best practice, IOM's Service Agreement (Section E) describes the onboarding procedures for the personnel, which range from ensuring required vaccinations to arranging transportation and induction training, and clearly delineates which tasks are the responsibilities of the IOM and of the contractors. By including such a description in the Service Agreement, the contractors are legally obligated to implement the standards required by IOM, and IOM in return, has a mechanism to verify that the contractors are capable of adopting the required standards.

5. In addition to this, the contractors may, on their own decision, take any measures necessary to ensure the security and safety of their personnel, in the event of imminent and unexpected risks. However, as there are cost implications, the contractors and the contracting UN organizations are encouraged to liaise with each other on a regular basis, especially on security matters, so that any additional measures beyond the minimum standards required in the contract may be approved by the contracting UN organization in advance.

6. Therefore, the Task Force recommends and encourages UN organizations to consider incorporating these provisions in their Service Agreements with contractors, as has been done by IOM. The below table further describes the suggested responsibilities and actions to be taken by the involved parties (i.e. Contractor, non-UN personnel and the UN organizations).

Prior to deployment:

Measures to be provided/actions to be taken	Suggested actions by the contractor (TPC/IP)	Suggested actions by the UN organization	Suggested actions by the non-UN personnel
Provision of detailed information	Provide thorough information on the work, working conditions and duty station to the individual.	Define clear ToRs and conditions of service, which can be communicated to the personnel via the contractor well in advance of deployment. Share its pre-deployment guide, organization-specific information and the country-specific factsheet with the personnel, if available.	Properly understand the work and working conditions and make the decision to take on the assignment based on the information provided. Disclose concerns prior to signing contract with the contractor.
Medical clearance	Verify that the individual is medically fit to work in the duty station.	Provide guidance on the criteria to be used for the fitness assessment, including the required vaccinations, according to the area of deployment.	Provide the partner/contractor with a medical certificate (from a licensed medical professional/ health care provider) that s/he is medically fit to work in the duty station, as specified by the contractor.
Security clearance	Verify and assess the security of the travel to the duty station and provide the clearance.	Provide security information if and as appropriate to the contractor.	Cooperate with the security clearance procedures of the contractor as necessary.
Secure travel and visa arrangements	Arrange the travel of the individual to the duty station and assist in the identification of a secure residence. Arrange a visa for the personnel to enter the country of the duty station.	Provide support for visa application as appropriate, on a voluntary basis.	Travel in accordance with the agreed travel plan. Cooperate with the visa procedures as instructed by the contractor.
Reasonable accommodation of disability and other special needs	Define the policy and standards of required non-discrimination and disability and ensure compliance.	Provide the organization's policy on non-discrimination to the contractor for their information. Whenever possible, accommodate limitations/disability. Alert the contractor for their action in case non-compliance is identified.	Adhere to the non-discrimination policy at the individual level.
Certification of appropriate insurance coverage	Ensure that each personnel has the necessary health insurance coverage (including medical evacuation if applicable), occupational and non-	Define the minimum insurance and medevac requirements, require and verify that the contractor has the appropriate insurance.	Accept the insurance coverage offered by the contractor or purchase insurance which complies with the required minimum standards.

	occupational, whether by offering the insurance or verifying that each personnel has obtained insurance which complies with the required minimum standards.		

During deployment:

Measures to be provided/actions to be taken	Suggested actions by the contractor (TPC/IP)	Suggested actions by the UN organization	Suggested actions by the non-UN personnel
Ongoing dissemination of security/medical and other relevant information	Provide a security briefing prior to or at the time of deployment to all personnel. Update the individual with the latest security/ medical information.	Inform contractor on the contents of the security briefing. Provide security briefing directly to the personnel if agreed with the contractor. Share any updated security/medical information with the contractor.	Attend the security briefing. Follow instructions as provided by the contractor and adjust actions accordingly.
Inclusion under the security system in place	Set up and operationalize security protocols for the movement and other activities of the personnel. Assign a security focal point and/or establish an operations center for day-to-day security management. Provide personnel with a proper and valid identification card.	Inform contractor on security mechanisms as well as security information the organization has access to, as well as maintain regular contact with the contractor. Require in contract that the contractors provides necessary equipment to the employee as defined in the security protocols. Conduct security reviews, if deemed necessary, to identify whether the contractor's security mechanism is properly maintained and advise contractor if it is not in accordance with the requirements of the contract..	Adhere to the security procedures as required by the contractor. Comply with the organization's policy on the use of IDs.
Accommodation standards	Ensure that the accommodation of the individual meets the security standards.	Inform contractor of the necessary security standards. If available, offer UN-based accommodation matching the standards at the cost of the contractor.	N/A
Adequate bandwidth provided	Provide access to bandwidth if operating in locations without the presence of the organization, or	Define the necessary bandwidth as appropriate.	Comply with organization's policy on the use of organization's bandwidth (e.g. do

	whenever contracted to provide such services.		not use bandwidth to watch/download inappropriate content)
Access to available medical and psychosocial services	Ensure that the employees have access to medical, including telehealth and mental health, services for the employee as agreed with the contracting UN organization.	N/A	Pay for the services upfront for later reimbursement from insurances, if applicable in the insurance scheme.
Access to medical evacuation services and insurance coverage	Define operational procedures for medical evacuation and ensure that it is physically available at the duty station where the employee is deployed and that the cost is covered by insurance.	Monitor that the medical evacuations are administered appropriately.	N/A
Compensation commensurate with the work and working conditions	Provide leave and other entitlements as required by the local labor law and in accordance with the policy on entitlements as defined by the UN organization.	Ensure contract with contractor requires contractor to comply with applicable laws in respect of the employment of its personnel, including in relation to compensation, medical and other coverage, leave and other entitlements.	Exercise rights to take leave as a means of self-care.
Trainings and learning opportunities	Ensure that the individuals complete the mandatory training courses, whether using external materials (e.g. BSAFE, PSEA/gender awareness, ethics) or conducting its own training.	Define the minimum training requirements and inform contractor on any additional trainings to be provided by the contractor. Provide functional/thematic trainings which will support the personnel in his/her required for successful completion of the work, as appropriate.	Complete all mandatory trainings in the required timeframe.
Protection against SEA, sexual harassment, harassment, abuse of authority and retaliation.	Ensure policies and a framework to address PSEA and other misconduct and handle any suspected cases in line with the policies to ensure accountability.	Ensure the contract includes the required standards of conduct and handle any suspected cases which involve the organization's own staff, to ensure accountability.	Adhere to the PSEA and other policies on conduct.
Follow-up mechanism in case of distress	Define the protocols for suspected cases of distress and ensure that the support (psychosocial and medical) is available.	Inform the contractor of the situation and monitor its follow-up.	Seek help when under distress at an early stage.

Crisis management	Define the protocols for, and act accordingly in the event of security incidents, such as hostage taking, arrest and detention and occupational accidents.	Inform contractor of the protocols and define the mode of cooperation and communication with the contractor in case of security incidents.	Follow and act in accordance with the security protocol and advice, prior to and during the incident.
Terms in the contractual agreement describe the mechanism for dispute resolution.	Set up and operationalize a grievance mechanism through which an individual can raise complaints about administrative decisions, as well as workplace and other issues.	Consider including a requirement in the contract with contractor requiring contractor to provide its personnel with appropriate grievance mechanisms.	Adhere to whistle-blowing and other policies as required.
Appropriate ongoing support for the fair assessment of performance	Ensure that all personnel receive a periodic performance evaluation, at a frequency and with the items as agreed in the contract.	N/A	Participate in the performance evaluation process in good faith.

Post deployment:

Measures to be provided/actions to be taken	Suggested actions by the contractor (TPC/IP)	Suggested actions by the UN organization	Suggested actions by the non-UN personnel
Development and implementation of a mechanism to collect and reflect on the feedback from the personnel	Conduct an exit interview/survey to identify any issues.	Take into consideration the results of the exit survey to ensure that improvements are made to improve performance, if appropriate.	Respond to the interview/survey in good faith and report all incidents.
Certificate of service/successful performance, if applicable.	Provide appropriate work reference for the individuals.	N/A	N/A
Timely settlement of final emoluments as provided in the contractual agreement	Pay all separation entitlements to the individuals.	N/A	Complete tasks as required and return all assigned assets to the UN immediately upon separation.
Follow-up mechanism in case of long-term effects of occupational illnesses/accidents	Provide psychological care and follow-up to those who exited the operation due to occupational accidents/illnesses.	N/A	N/A

D. Examples of how the Voluntary Guidelines could be implemented (Affiliate and Standby Personnel)

Annex 2 provides examples of how UN organization can implement the voluntary guidelines for affiliate and standby personnel regarding:

- Medical certificate and health insurance;
- Medical evacuation (if required);
- Compensation for service incurred injury, illness and death; and
- Mandatory training.

Example 1: Guidance for medical certificate and health insurance

- Medical certificate from a medical profession/health care provider confirming that the individual:
    - is medically fit to work in the designated duty station for the duration of the assignment, for the role he/she is assigned to do;
    - has up-to-date vaccination(s) as recommended by WHO for the duty station and if applicable, any other duty station(s) which the individual is expected to travel during the assignment; and
    - is in overall good health.

- Health Insurance:
    - Health insurance which is valid in the duty station and any other duty station(s) which the individual is expected to travel during the assignment;
    - Insured amount which is adequate as per the local context of the duty station(s)
    - Additional duty station-specific coverage (e.g. if duty station is in an Ebola affected area, the insurance must cover for Ebola)

Example 2: Guidance on medical evacuation insurance (if required)

(For example, medical evacuation insurance may not be required if the individual is recruited locally)

- Duty station specific minimum requirement for medical evacuation, which is valid for the duration of the assignment.

- Amount of coverage depends on the local condition but must be sufficient to evacuate the individual from the duty station or another duty station while on official travel to the nearest international point of medical evacuation.

Example 3: Guidance on compensation for service incurred injury, illness and death

Provisions specific in the contract for compensation in the event of service incurred injury, illness or death. Organizations may consider opting to provide compensation similar to Appendix D of the United Nations Staff Regulations and Rules (Option 1) or providing a lump sum (Option 2).

Option 1: Compensation similar to Appendix D of the United Nations Staff Regulations and Rules or per relevant Staff Rules applicable for each organization – to be specified in the contract.

<u>In the event of a service-incurred injury or illness:</u>

- Expenses: all medical expenses which are: (i) Directly related to a service-incurred injury or illness; (ii) Reasonably medically necessary for the treatment or services provided; and (iii) At a reasonable cost for the treatment or services provided.

- Total disability: annual compensation equivalent to 66.66 per cent of his or her last take home pay or, if the individual has a dependent child, 75 per cent of the last take home pay. Such compensation shall be payable at periodic intervals for the duration of the disability.

In the event of a service-incurred death:

- Funeral costs: a reasonable amount for the preparation of the remains and for funeral expenses, but no more than three times the monthly G-2, step I, pensionable remuneration applicable at the time of death for the country where the funeral takes place, or, where there is no pensionable remuneration scale for the country where the funeral takes place, the pensionable remuneration scale for Headquarters in New York.

- Expenses: all medical expenses incurred prior to the date and time of a death which are: (i) Directly related to a service-incurred injury or illness; (ii) Reasonably medically necessary for the treatment or services provided; and (iii) At a reasonable cost for the treatment or services provided.

- Travel and repatriation costs: Expenses for the travel of an eligible family member to attend the funeral or for an eligible family member or other designated individual to accompany the remains of a deceased staff member as well as the costs for the repatriation of the remains.

- Compensation: the compensation provided a) to the affiliate/standby personnel's spouse or b) other eligible dependent(s), as below, provided that the total annual compensation payable shall not exceed 75 per cent of the last take home pay of the deceased member of the affiliated workforce.

    a. Spouse: A spouse shall receive annual compensation payments, payable at periodic intervals, equal to 50 per cent of the deceased member of the affiliated workforce last take-home pay.

    b. Dependent child: Each dependent child shall receive annual compensation, payable at periodic intervals, equal to 12.5 per cent of the deceased member of the affiliated workforce last take-home pay.

Option 2: Example of a lumpsum[4].

	Person engaged from outside of their home country (i.e. an international)	**Person engaged from within commuting distance of the duty station (i.e. a local)**	**Retired UN staff engaged as a member of the affiliate workforce to work outside of their home country (i.e. an international)**	**Retired UN staff engaged as a member of the affiliate workforce from within commuting distance of the duty station (i.e. a local)**
Maximum Compensation (per person)	USD 280,000	USD 160,000	USD 40,000	USD 20,000
Injury	Death: USD 180,000 Permanent total Disablement: USD 180,000	Death: USD 80,000 Permanent total Disablement: USD 80,000	Death: USD 20,000 Permanent total Disablement: USD 20,000	Death: USD 20,000 Permanent total Disablement: USD 20,000

[4] This example is from UNDP. Kindly note UNDP is currently reviewing the coverage.

	Person engaged from outside of their home country (i.e. an international)	Person engaged from within commuting distance of the duty station (i.e. a local)	Retired UN staff engaged as a member of the affiliate workforce to work outside of their home country (i.e. an international)	Retired UN staff engaged as a member of the affiliate workforce from within commuting distance of the duty station (i.e. a local)
	Permanent Disablement: A percentage of USD 180,000 relative to the degree of disability.	Permanent Disablement: A percentage of USD 80,000 relative to the degree of disability. Medical Expenses Extension: USD 80,000	Permanent Disablement: A percentage of USD 20,000 relative to the degree of disability.	Permanent Disablement: A percentage of USD 20,000 relative to the degree of disability. Medical Expenses Extension: USD 20,000
Illness	Death: USD 180,000 Permanent Total Disablement: USD 180,000	Death: No compensation Permanent Total Disablement: No compensation	Death: USD 20,000 Permanent Total Disablement: USD 20,000	Death: No compensation Permanent Total Disablement: No compensation
Medical Expenses	Medical Expenses: USD 100,000	Medical Expenses: No compensation	Medical Expenses: USD 20,000	Medical Expenses: No compensation

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Example 4: Suggested mandatory training courses

- BSAFE training: UNDSS training course.
- Prevention against Workplace Harassment, Sexual Harassment and Abuse of Authority.
- Prevention against Sexual Exploitation and Abuse.
- Ethics course(s).

E. Excerpt from IOM's Service Agreement for non-UN personnel

Below is an excerpt from IOM's Service Agreement with a contractor (TPC/IP), which describes relevant services, obligations and operating procedures.

IOM's Service Agreement includes: recruitment, employment offer, medical check and deployment, HR management, payroll services and invoicing, asset administration, reporting and audit, security and additional services.

*C = Contractor (TPC/IP)

Tasks	C	IOM	Description and Timeline (if applicable)
B.3 Vaccination	✓		C instructs the selected candidate who accepted the initial offer to get the required vaccinations. The following vaccinations are considered compulsory for this type of mission and need to be up to date: [Yellow Fever vaccine, Diphtheria-tetanus-polio (pertussis), Hepatitis A and B, and Typhoid].
B.4 Medical clearance	✓		C's authorized medical doctor medically clears the candidate, and C submits to IOM a "fit to work and travel" certificate for the expected duration of the assignment, along with a vaccination card updated with vaccinations recommended by WHO, and a copy of the blood group card or laboratory result.
B.5 Insurance coverage	✓		C either provides non-occupational and occupational health insurance covering accidents and illnesses to the personnel with a minimum coverage as provided in "Insurance Coverage" or ensures that s/he has an insurance meeting the minimum coverage and keeps a copy of the policy, prior to deployment. The insurance shall cover the whole contract period and shall be extended prior to any extension.
B.6 Travel to the duty station	✓		C ensures that the personnel travels to the place of duty assigned by IOM within [30] days of confirmation of selection (detailed schedule is to be agreed between IOM and C), and provides assistance with obtaining and renewing visas (including transit visas) and/or work permit, travel from/to the nearest airport, and finding a suitable accommodation. C arranges the travel to the place of duty through its registered agent ([return economy flight if by air]), following written approval of the route and costs by IOM. Visas must not be obtained in a clandestine manner, and if requested by IOM, C informs IOM of the methodology by which visas are obtained and offers another type of visa for entry if it is suspected that a proposed visa may be problematic or inappropriate. IOM assists C in obtaining visas wherever and to the extent possible.
B.7 Orientation and training	✓		C provides and ensures that all the personnel participate in the following trainings prior to the commencement of the work: Initial detailed orientation including the culture of the place of duty, Security briefing including evacuation procedures.

Annex 5. High Level Budget and Resource Contributions 2019-20: Summary for Mental Health Strategy Implementation

High level budget:

Item	Indicative Budget 2019	Indicative Budget 2020	Total
Governance	$6,500	$6500	$13,000
Management	$440,000	$545,000	$985,000
Evaluation	$60,000	$40,000	$100,000
Communication	$130,000	$100,000	$230,000
Priority Action 1	$30,000		$30,000
Priority Action 2	$100,000	$120,000	$220,000
Priority Action 3	$40,000	$140,000	$180,000
Priority Action 4	$30,000	$90,000	$120,000
Priority Action 5	$20,000		$20,000
Priority Action 6	$10,000	$40,000	$50,000
Priority Action 7	NA		
Total	$1,015,000	$910,000	$1,925,000

Contributed funds:

Organization/Entity/Department:	Dollar Amount (USD):
OHR (UN Secretariat)	$520,000
WIPO	$20,000
WHO	$10,000
UNICEF	$30,000
UN Women	$15,000
DoS (UN Secretariat)	$142,400
UNDP	$100,000
ILO	$10,000
UN Cares	$20,000
UNHCR	$96,000
Total:	**$963,400**

Annex 5. High Level Budget and Resource Contributions 2019-20: Summary for Mental Health Strategy Implementation

In-Kind support:

Area	Organization/Entity	Support given
Board Members	ILO, IOM, UNAids, UNDP, UNFPA, UNICEF, UNHCR, UNISERV, UNOMS, UN Secretariat, UN Women, WFP, WHO, WIPO. CCISUA, CISMU, FICSA, UNMD, UNSSCG	Attendance at monthly Board Meetings Attendance at annual 2-day meeting (including travel and accommodation costs)
Project Sponsors	World Bank, IOM, UNHCR, WHO, FICSA, UN Secretariat, UNICEF	Variable. Up to 2 hours per week.
Working Group Members	UNDSS, UNFPA, World Bank, IOM, UNHCR, WHO, FICSA, UN Secretariat, UNICEF, ILO, WFP, UN Secretariat	Variable. Up to 4 hours per week.
Management support for Global Lead	UN Secretariat (OHR)	Line Management Support
Secretariat Support for the Board	UN Secretariat (OHR)	Logistics for meetings, meeting minutes up to 10 hours per month.

UNMD UNITED NATIONS MEDICAL DIRECTORS		MHSE Gap Analysis & Risk Controls					
Duty Station:		**Local Provider available and accessible as needed?**	**If not/partially covered, can current UN capacity compensate?**	**describe basis for rating.**	**MHSE appropriately addressed?**	**Actions needed to fully implement Mandatory Health Support Elements**	**Risk Controller**
	Element Description						
Mandatory Health Support Elements (MHSE)	**Primary Care**	yes	no		yes		
	Hospital Care	partial	n/a		no		
	Mental Health Services				partial		
	Mass Casualty Plan				n/a		
	Medical Emergency Response						
	Access to pharmaceuticals, incl. PEP						

Form 1 : Assessment of Primary Care Facility

Name of facility:
Type of facility:
Registration number :
Date
Address:

Number of staffs:	**Number (Full-time equivalent)**	**Comments**
Medical Doctor GP		
Paediatrician		
Registered Nurse:		
Auxiliary Nurse		
Laboratory Assistant:		
Radiologist		
Pharmacist:		
Physiotherapist		
Receptionist:		
Other:		
Infrastructure:	**Yes/No**	**Comments**
Waiting room		
Reception area		
Consultant room		
Small Surgery room		
Dressing room		
Pharmacy		
Laboratory		
Xray room		
Vaccination room		
Toilets		
General storage		
Regrigarated storage for vaccines and drugs		
Ambulance		
Other:		
Attendance	**Yes/No**	
The clinic attendance hours are at least 8h per day, 5 days a week		
The clinic has a system for off-duty physician on call 24/7		
Standards	**Yes/No**	**Comments**
Mandatory Standards (if not compliant, assessment stops here)		
Staff has been trained in Basic and/or Advanced Life support techniques		
Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly, when required.		
Does the clinic have a practitioner trained in Basic Gynecological and obstetrical care (ANC, pregnancy monitoring, contraception, preventive care, etc..)		

UN International Patient Safety Goals		
1. The clinic has a process to improve accuracy of patient identification (if applicable)		
2. The clinic has a process to ensure that all orders are written		
3. The clinic has a process for reporting critical results of diagnostic tests.		
4. The clinic has a process for handover communication.		
Data management		
5. The clinic has an in-house ethical code signed by medical practitioners		
6. Information privacy, confidentiality, and security, including data integrity, are maintained.		
7. Records and information are protected from loss, destruction, tampering, and unauthorized access or use.		
8. The medical record contains sufficient information to identify the patient, to support the diagnosis, to justify the treatment, and to document the course and results of treatment		
9. The clinic has a protocol regarding those who are authorized to make entries in the patient clinical record.		
Clinical Focused Standards		
Clinical Assessement		
10. An initial assessment/screening process is used to identify the healthcare needs of all patients.		
11. All outpatients are screened for pain and assessed when pain is present.		
12. Children are systematically assessed for fever		
13. Clinical guidelines and pathways based on WHO standards are used to support consistency in care.		
14. The care provided to each patient is planned, revised when indicated by a change in the patient's condition and documented in the patient record.		
15. Clinical and diagnostic procedures and treatments performed, and the results or outcomes, are documented in the patient's		
16. The care of high-risk patients are guided by professional practice guidelines.		
17. Clinical staff is trained to recognize and respond to changes in a patient's condition.		
19. Patient follow up instructions are given in a form and language the patient can understand.		
20. Patient education and instruction are related to the patient's continuing care needs.		

Pharmaceuticals		
21. The clinic implements a uniform process for prescribing patient orders.		
22. If the clinic has a pharmacy, it is stocked with sufficient quantity and variety of essential emergency drugs, according to the National Essential Drug list		
23. Medications are properly and safely stored (if applicable)		
Referral – MEDEVAC		
24. The clinic has a process to refer patients to other healthcare settings to meet their continuing care needs.		
25. The clinic carries out processes to provide continuity of patient care services in the clinic and coordination among health care practitioners.		
26. The referring clinic follows procedures for the medevac of patients to ensure they patients are transferred safely.		
27. The receiving hospital is given a written summary of the patient's clinical condition and the interventions provided by the referring clinic.		
28. The medevac process is documented in the patient's record.		
Administration-Focused Standards		
29. The clinic follows an adverse event reporting process.		
30. Patient satisfaction is monitored systematically.		
Safety		
31.The clinic adopts and implements WHO guidelines for Hand Hygiene and Universal Precautions in Health Care to reduce the risk of health care-associated infections		
32. All patient and staff areas of the clinic are included in the infection prevention and control program.		
33. The clinic tracks infection risks, infection rates, and trends in healthcare associated infections to reduce the risks of those infections.		
34. The clinic reduces the risk of infection through proper disposal of biomedical waste.		
35. The clinic implements practices for safe handling and disposal of sharps and needles.		
36. The clinic controls the use of hazardous materials and biomedical equipment.		
37. There is an SOP and equipment to ensure that all occupants of the clinic are safe from fire, smoke and other emergencies.		
38. Safe drinking water and electrical power are available during hours of clinic operation to meet essential patient care needs.		

Source:

UN Manual for Healtcare and Patient safety in UN-Clinics, DPKO, draft 2018

Form 1 B Assessment of Laboratory
(standalone or hospital laboratory)

Name of facility:
Type of facility:
Date :
Registration number :
Address:

Number of staff:	**Number**	**Comments**
Medical Doctor		
Biologist		
Laboratory Assistant:		
Receptionist, admin		
Other:		
Services		
Hematology		
Microbiology/Parasitology		
Bioquimical/Serology		
Hormonal		
Culture Antibiogram		
Microscopy		
Infrastructure:	**Yes/No**	**Comments**
Waiting room		
Reception area		
Sampling taking room		
Toilets		
General storage		
Other: generator, refrigerators, etc.		
Attendance	**Yes/No**	
The lab attendance hours are at least 8h per day, 5 days a week		
The lab has a system for off-duty analysis on call 24/7		
Standards	**Yes/No**	**Comments**
Mandatory Standards (if not compliant, assessment stops here)		
A qualified individual(s) is responsible for managing the clinical laboratory service or pathology service.		
All equipment and medical technology used for laboratory testing undergoes a regular internal and external quality control process/calibration		
UN International Patient Safety Goals		
Patient Identification		
1. The laboratory has a process to improve accuracy of patient identification.		
Improve Effective Communication		
2. The laboratory has a process to ensure that all orders are written.		
3. The laboratory has a process for reporting critical results of diagnostic tests and critical events.		

Reduce the Risk of Health Care-Associated Infections		
4. The laboratory implements WHO Guidelines for Hand Hygiene and Universal Precautions in Health Care to reduce the risk of healthcare–associated infections.		
Clinical Focused Standards		
Access to Care (UNAC)		
5. At admission, patients receive information on the exams and procedures		
6. All laboratory staff members have the required education, training, qualifications, and experience to administer and perform laboratory tests and interpret the results, as per national standards.		
7. The laboratory uses a coordinated process to reduce the risks of infection because of exposure to bio-hazardous materials and waste.		
8. All equipment and medical technology used for laboratory testing is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.		
9. Clinical and diagnostic procedures and the results or outcomes, are documented in the patient's record.		
Patient and Family Education		
10. Patients and, when appropriate, their families receive education they can understand to support their participation in their care (for example, granting consent).		
Administration-Focused Standards		
Prevention and Control of Infections		
11. The laboratory reduces the risk of infection through proper disposal of biomedical waste.		
12. The laboratory implements practices for safe handling and disposal of sharps and needles.		
13. Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly, when required.		
Facility Management and Safety		
14. There is an SOP and equipment (fire alarm, extinguishers) to ensure that all occupants of the laboratory are safe from fire, smoke and other emergencies.		
15. There is an organized program for the safe management of biomedical equipment		
16. Safe drinking water and electrical power are available 24 hours a day, seven days a week, through regular or alternate sources, to meet essential patient care needs.		
17. The laboratory developed, maintains, and tests an emergency management program to respond to emergencies and natural or other disasters according to the national emergency preparedness plan.		

Staff Health and Safety		
18. There is a program to reduce health hazards for staff and to provide safe working conditions		
Management of Information		
19. Information privacy, confidentiality, and security, including data integrity, are maintained		
20. Records and information are protected from loss, destruction, tampering, and unauthorized access or use (backup or hard copy)		
21. The medical record contains sufficient information to identify the patient, the procedures and the results		
22. The laboratory has a protocol regarding those who are authorized to make entries in the patient clinical record.		

Source:

UN Manual for Healthcare Quality and Patient Safety, Draft 2018, DPKO

Form 2 : Assessment of Referral Hospital

UNMD
UNITED NATIONS MEDICAL DIRECTORS

Name of facility:
Type of facility:
Registration number :
Date :
Address:

Number of staff:	**Number**	**Comments**
Medical Doctor GP		
Paediatrician		
Surgeon		
OB/GYN		
Internist		
Anesthesist		
Other:		
Registered Nurse:		
Auxiliary Nurse		
Laboratory Assistant:		
Radiologist		
Pharmacist:		
Physiotherapist / Occupational therapist		
Receptionist, admin		
technical staff		
Other: kitchen, generator, sterilisation, cleaning, maintenance		
Infrastructure:	**Yes/No**	**Comments**
Waiting room		
Reception area		
Triage center		
Consultant room (number)		
Small Surgery room (number)		
Operation theater (number)		
Post Op room (number)		
Dressing room (number)		
Obstetrical ward		
Emergency ward		
Intensive Care Unit (number of beds and type)		
Inpatient facilities (number of beds)		
Pharmacy		
Refrigerated vaccine storage		
Bloodbank		
Xray department (specify services)		
Laboratory (specify services)		
Mortuary		
Toilets		
General storage		
Other: groupe 500kVa, cuisine, buande		
Attendance	**Yes/No**	
The hospital attendance hours are 24 h per day, 7 days a week		
The hospital has a system for off-duty physician on call 24/7		
Standards	**Yes/No**	**Comments**
Mandatory Standards (if not compliant, assessment stops here)		
Resuscitation services are available throughout the hospital and contain at least a manual ventilator (bag mask), defibrilator and essential drugs.		

Staff has been trained in Basic and/or Advanced Life support techniques		
Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly, when required.		
A qualified individual(s) is responsible for managing the clinical laboratory service or pathology service.		
A qualified radiologist is available for interpreting results of the exams on site or through teleconsultation or on call		
Is there a business continuity system in place in the case the ICU specialist is not available ?		
Does the hospital have a practitioner trained in Comprehensive Gynecological and emergency obstetrical care (ANC, pregnancy monitoring, complicated deliveries, contraception, preventive care, etc..)		
UN International Patient Safety Goals	**Yes/No**	**Comments**
1. The hospital has a process to improve accuracy of patient identification (single identification number)		
2. The hospital has a process to ensure that all orders are written and kept in the patient record.		
3. The hospital has a process for reporting critical results of diagnostic tests and critical events.		
4. The hospital has a process for handover communication.		
5. The hospital has a process for ensuring correct-site, correct-procedure, and correct-patient surgery.		
6. The hospital implements WHO Guidelines for Hand Hygiene and Universal Protection in Health Care to reduce the risk of healthcare–associated infections.		
Clinical Focused Standards		
Access to Care (UNAC)		
7. The hospital has a process for admitting patients with emergent needs and does triage on basis of emergency, particularly for children.		
8. At admission as an inpatient, patients receive information on the proposed care and the expected outcomes of care.		
Assessment of Patients (UNAP)		
9. All patients cared for by the hospital have their health care needs identified through an assessment process that has been defined by the hospital.		
10. All inpatients and outpatients are screened for pain and assessed when pain is present.		
11. All patients are reassessed at intervals based on their condition and treatment to determine their response to treatment and to plan for continued treatment or discharge.		
Care of Patients (UNCP)		
12. An individualized plan of care is developed and documented for each patient and is kept in the patient record		
13. The hospital implements a uniform process for prescribing patient orders.		
14. Clinical and diagnostic procedures and treatments performed, and the results or outcomes, are documented in the patient's record.		

15. The care of high-risk patients and the provision of high-risk services are guided by professional practice guidelines, clinical pathways, and policies.		
16. Clinical guidelines and procedures established are implemented for the handling, use, and distribution of blood and blood products.		
17. Patients are supported in managing pain effectively.		
18. The hospital offers OBGYN services compatible with Comprehensive Emergency Obstetrical Care, offering at least surgery for complications of delivery and blood transfusion.		
19. The hospital offers full pediatric services		
Continuity of Care (UNCC)		
20. The hospital carries out processes to provide continuity of patient care services in the hospital and coordination among health care practitioners.		
with the patient when transferred within the hospital.		
22. A complete discharge summary is prepared for all inpatients.		
23. Patient education and follow-up instructions are given in a form and language the patient can understand.		
24. The clinical records of inpatients contain a copy of the discharge summary.		
25. The hospital has a process for the management and follow-up of patients who intend to leave against medical advice.		
MEDEVAC		
26. Patients are medevaced to the next level of care based on their medical status, and the ability of the receiving organization to meet patients' needs		
27. The referring hospital follows procedures for the medevac of patients to ensure that patients are transferred safely.		
28. The receiving hospital is given a written summary of the patient's clinical condition and the interventions provided by the referring hospital.		
29. The medevac process is documented in the patient's record.		
Laboratory (basic standards, for full assessment, use form 1b)		
30. Laboratory services are available to meet patient needs.		
31. All laboratory staff members have the required education, training, qualifications, and experience to administer and perform laboratory tests and interpret the results.		
32. The laboratory uses a coordinated process to reduce the risks of infection because of exposure to bio-hazardous materials and waste.		
33. All equipment and medical technology used for laboratory testing is regularly inspected, maintained, calibrated, and appropriate records are maintained for these activities.		
34. The laboratory applies both an internal and external calibration and quality assessement on a daily basis.		
35. The laboratory has sufficient consumables for at least one month of operation		

Radiology		
36. Radiology and diagnostic imaging services are available to meet patient needs, and all such services meet applicable radiation protection		
37. A qualified individual(s) is responsible for managing the radiology and diagnostic imaging services.		
38. A radiation safety program is in place, followed, and documented, and compliance with the facility management and infection control programs is maintained.		
Intensive Care Unit		
39. There is a daily regular attending physician, accredited specialist in Intenisve care medecine in the ICU		
40. The ratio of regular attending physicians per bed is at least 1:10 per shift		
41. The ratio of nurses or nurse technicians on duty per bed is at least 1:2 beds per shift		
42. A systematized and regular ICU centered training program is available for professionals before and during assignenment to the ICU		
43. There are written protocols for the main emergency pathologies (Stroke, hearth attack, trauma, coma, obstetrical and paediatric emergencies, etc.)		
44. There are written protocols for the prevention of main ICU complications (pneumonia, gastro-intestinal bleeding, embolism, etc..)		
45. There are daily multidisciplinary discussions of current cases among all type of staff		
46. There is a monitor and an oxygen dispenser available per bed		
47. There is at least one electrocardiography device per 10 beds		
48. There is at least one transport ventilator (adult and paediatric) per 10 beds		
49. There is at least one crash defibrillator per 5 beds		
50. The ICU conducts prescheduled meetings with relatives of patients to provide information on state of health and care they need		
Anesthesia and Surgical Care (UNAS)		
51. Sedation and anesthesia services are available to meet patient needs, and are under the supervision of the facility's specialty anesthetist.		
52. There is a pre-sedation assessment of the patient performed by a qualified professional, under the supervision of the facility specialist		
53. A qualified individual, under the supervision of the facility specialist anesthetist, conducts a pre-anesthesia assessment and pre-induction		
54. Each patient's anesthesia care is planned and documented, and the anesthesia and technique used are documented in the patient's record.		
55. Each patient's physiological status during anesthesia and surgery is monitored according to WHO professional practice guidelines and documented in the patient's record.		

56. Each patient's post anesthesia status is monitored and documented and the patient is discharged from the recovery area by a qualified individual.		
57. Each person's surgical care is planned and documented based on the results of the preoperative assessments, and pre-operative		
58. The risks, benefits, and alternatives to surgery are discussed with the patient and/or those who make decisions for the patient.		
59. Information about the surgical procedure is documented in the patient's medical record to facilitate continuing care. (See UN-IPSG.3)		
Medication Management (UNMM) basic standards, for full assessment use form 4		
60. A written document identifies how medication use is structured and managed throughout the hospital. Medication use is overseen by a qualified		
61. Medications are properly and safely stored (check visually)		
62. A system is used to safely dispense medications in the right dose to the right patient at the right time.		
63. Medication effects on patients are monitored.		
Administration-Focused Standards		
64. The hospital follows an adverse event reporting process		
65. Patient satisfaction is monitored.		
66. Clinical guidelines and pathways are used to support consistency in care.		
67. The hospital undertakes a prevention and reduction program for health care-associated infection based on the WHO Standard Universal Precautions.		
68. The hospital tracks infection risks, infection rates, and trends in health care-associated infections to reduce the risks of those infections.		
69. The hospital reduces the risk of infections by ensuring adequate medical technology cleaning and sterilization, and the proper management of laundry and linen.		
70. The hospital implements practices for safe handling and disposal of sharps and needles and proper disposal of biomedical waste		
71. Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly, when required.		
72. Leaders evaluate clinical outcome and admission data to support staff performance and track trends over time		
Facility Management and Safety		
73. The hospital facility and buildings are thoroughly inspected to ensure awareness of risks that could affect patients and staff, and to plan for continuously improving the safety of the environment.		
74. There is an SOP and adequate equipment (smoke detectors, fire extinguishers) to ensure that all occupants of the hospital are safe from fire, smoke and other emergencies and simulation takes place.		
75. There is an organized program for the safe management of biomedical equipment and hazardous waste		

76. Safe drinking water and electrical power are available 24 hours a day, seven days a week, through regular or alternate sources, to meet essential patient care needs.		
78. The hospital has developed, maintains, and tests an emergency management program to respond to emergencies and natural or other disasters that have the potential of occurring where the hospital is located.		
79. There is a program to reduce health hazards for staff and to provide safe working conditions		
Staff Qualifications and Education		
80. Technical clearance for all medical service providers and staff has been checked and archived		
81. All physicians, nurses & clinicians follow the ethical code for medical practitioners and the principles of medical ethics.		
82. Staff members who provide patient care are trained in resuscitative techniques (ALS) prior to commencement of staff rotation.		
83. There is a continuous education programme for maintaining and updating skills of staff for the use of clinical pathways and BLS		
Management of Information		
84. Information privacy, confidentiality, and security, including data integrity, are maintained		
85. Records and information are protected from loss, destruction, tampering, and unauthorized access or use.		
86. The medical record contains sufficient information to identify the patient, to support the diagnosis, to justify the treatment, and to document the course and results of treatment		
87. The clinical records of patients receiving emergency care include the time of arrival and departure, the conclusions at termination of treatment, the patient's condition at discharge, and follow-up care instructions.		
88. The hospital has a protocol regarding those who are authorized to make entries in the patient clinical record.		
89. As part of its monitoring and performance improvement activities, the hospital has a clinical record review process to regularly assess patient clinical record content and the completeness of patient clinical records.		

Source:

UN Manual for Healthcare Quality and Patient Safety, Draft 2018, DPKO

Quality in intensive care units : proposal of an assessment instrument, BioMed Central, 2017

Form 3 : Assessment of Mental Health Facility
(standalone or outpatient facility of a hospital)

Name of facility:
Type of facility:
Registration number :
Date :
Address:

Number of staff:	**Number (full-time equivalent)**	**Comments**
Psychiatrist		
Psychologist		
Child Psychologist		
Medical Doctor		
Other:		
Psychiatrist Nurse:		
Auxiliary Nurse		
Receptionist:		
Other:		
Infrastructure:	**Yes/No**	**Comments**
Waiting room		
Reception area		
Consultant room		
Child friendly room		
Inpatient facilities		
Isolation Unit		
Pharmacy		
Toilets		
General storage		
Other:		
Attendance	**Yes/No**	
The clinic attendance hours are at least 8h per day, 5 days a week		
The clinic has a system for off-duty psychiatrist or Psychologist on call 24/7		
Standards	**Yes/No**	**Comments**
Mandatory Standards (if not compliant, assessment stops here)		
Service users can consult with a psychiatrist (or a medical doctor with at least 2 years of psychiatric training) or a psychologist (or occupational therapist) when they wish to do so		
The following psychotropic medication is available, at all times in sufficient quantity, including paediatric formulations : 1 psychotropic, 1 antidepressant, 1 antianxiety, 1 antiparkinsonian for side effects, 1 Antiepileptic, 1 bipolar disorder drug (mood stabilizor)		
Standards	**Yes/No**	**Comments**
1. The building is in a good state of repair		
2. The necessary resources, equipment are provided by the facility to ensure interaction and participation		

3. Private rooms within the facility are specifically designed for consultation and interview		
4. No person is denied access to facilities or treatment on the basis of economic factors or any other status (gender, religion, ethnicity, etc…)		
5. Everyone who requests mental health treatment receives care in this facility or is referred to another facility		
6. The facility has staff with sufficient diverse skills to provide counseling, psychosocial rehabilitation, prescription, information education and support to service users, family, friends or carers, in particular children		
7. Each service user has an individualized recovery plan that includes his or her social, medical, employment and education goals and objectives for recovery		
8. Recovery plans are driven by the service user, reflect his or her choices and preferences for care, are put into effect and are reviewed and updated regularly by the service users and a staff member		
9. Facilities link users with the general health care system, other levels of health care services or MEDEVAC		
10. Lithium dosage can be tested in the facility or referral laboratory		
11. Service users are informed about the purpose of the medication being offered and any potential side effects		
12. Service users are informed about treatment options that are possible alternatives to complement medication, such as psychotherapy and occupational therapy		
13. Service users preferences are the priority in all decisions about where they will access services		
14. Admission and treatment are based on the free and informed consent of service users		
15. Service users have the right to refuse treatment, except when sectioned under a Mental Health Act		
16. At all times, staff interact with service users in a respectful way, recognizing their capacity to understand information and make decisions and choices		
17. A personal, confidential medical file is created for each service user		
18. Service users have access to information contained in their medical files		
19. Staff members treat service users with humanity, dignity and respect, even in case of contention and electro convulsive therapy		
20. Alternatives to seclusion and restraint are in place and staff are trained in de-escalation techniques for intervening in crises and preventing harm to service users or staff		

Source:

WHO Quality Rights Tool Kit: Assessing and improving quality and human rights in mental health and social care facilities, Interview Tool, 2012

UNMSD Substance Abuse Facility evaluation

Form 4 : Assessment of Pharmacy
(standalone or hospital pharmacy)

Name of facility:
Type of facility (independent or attached to hospital)
Registration number :
Address:
Date :

Number of staff:	**Number (full-time equivalent)**	**Comments**
Pharmacist		
Auxiliary Pharmacist		
Clerk		
Cashier		
Other:		
Infrastructure:	**Yes/No**	**Comments**
Reception area		
Dispensing counter area		
Preparation area		
Storage room		
Refrigerated area		
Toilet and washroom		
Cashier		
Other:vaccination room etc..		
Attendance	**Yes/No**	
The pharmacy attendance hours are at least 8h per day, 5 days a week		
The pharmacy has a system for off-duty guard system		
Standards	**Yes/No**	**Comments**
Mandatory Standards (if not compliant, assessment stops here)		
Is the pharmacy licensed with the national Regulatory Authority (NRA) ?		
Has the pharmacy been inspected within the last year by the NRA		
Is the pharmacist registered by the National Order of Pharmacists or similar body ?		
Is there a trained pharmacist or nurse or pharmacy assistant present at all times ?		
System		
1. Is a prescription book/computer system available for recording data ?		
2. Does the system provide for recording date, patient, prescriber and drug name ?		
3. Are old prescriptions kept (according to national regulations) ?		
4. Does the pharmacy have a formalized stock management system based on stock cards or computerized inventory system ?		
5. Does the system enable to calculate/ control reorder levels ?		
6. Is stock on hand > 2 months of drug use ? (if pharmacy does not have access to daily ordering of drugs)		
7. There has NOT be any stock-out of essential drugs in the last 6 months		
8. Is the time between ordering and receiving drugs < 1 month ? (if applicable)		
Storage		
9. Is the facility and the storage room devoid of signs of pests ?		

10. Is the dispensing area clean and tidy ?		
11. Are there a toilet and hand washing facilities and are they clean and tidy ?		
12. Are Medicines protected from direct sunlight ?		
13. Are Medicines stored on shelves, systematically, in original packaging, labeled and under lock ?		
14. Is temperature monitored and regulated ?		
15. Are medicines requiring refrigeration and/or vaccines stored in a refrigerator and temperature monitored ?		
16. Are schedule 2 and 3 controlled drugs stored in a locked controlled drug safe ?		
17. Is there a procedure for expired drugs and are they stored separately ?		
18. Are there SOPs for storage, expiry date checking, dispensing of medicines ?		
19. Are stock balances checked against physical stock of drugs at least on a quartely basis ?		
Services		
20. Are opening hours at least 8 h per weekdays ?		
21. Are all areas of the pharmacy kept clean, well maintained and kept with hygiene standards ?		
Dispensing		
22. Are a drug formulary, catalogues, handbooks or essential drug list available ?		
23. Total number of items in stock > 500 ?		
24. Are there at least 4 different brands or generic cotrimoxazole tablets ?		
25. Are there paediatric formulations of the essential drugs ?		
26. Are there rapid diagnostic tests for pregnancy, HIV and malaria (if applicable) ?		
27. Average dispensing time per patient less than 3 min ?		
28. Are drugs dispensed either in original packaging, dispensing envelopes or appropriate containers ?		
29. Are clients provided the opportunity of buying the generic version of the drugs on a systematic basis ?		
30. Are deliveries counter checked before dispensing ?		
Rational drug use		
31. Are patients informed in writing or verbally of the correct dosage, method of administration, duration of therapy and storage of their prescription ?		
32. Are the patients informed about severe side-effects, adverse reactions or interactions and action to be taken if they occur (if not prescribed by MD) ?		
33. Does the pharmacist always check the prescription ?		
34. Would the pharmacy always sell antibiotics with a prescription except in case of emergency ?		
35. Does the pharmacy sell antimalarial treatment (CO-Artem) without prescription in case of emergency (if applicable) ?		
36. Are the majority (50%) of drugs prescribed dispensed in generic form ?		
Management and supervision		
37. Are staff aware of their roles and responsibilities and do they have required qualifications, training and competencies to carry out these roles ?		
38. Are there clear, documented procedures for the operation of the pharmacy ?		

Source:

Joint FIP/WHO Guidelines on Good Pharmacy Practice: Standards for Quality Pharmacy Services, October 2009
A new indicator based tool for assessing and reporting on GPP, Birna Trap et al., Southern Med Review, Vol 3, Issue 2, Oct 2010
Guide to completing the Pharmacy Assessment System, the Pharmaceutical Society of Ireland, October 2016

Form 5 Mass Casualty Incident Plan

Staff Interviewed
Date
Venue

Documents :	**Yes/No**	**Comments**
UN Security Plan		
Mass Casualty Incident Plan		
MEDEVAC Procedures		
Updated list of contacts		
Updated list of medical facilities		
Updated list of Medical Examining Physicians (MEP)		
Standards	**Yes/No**	**Comments**
Medical Threat and Risk Analysis		
1. Is the MCIP up to date according to the guidelines ? List date		
2. Is there a Medical threat and risk analysis in the MCIP ?		
3. Is it a Health risk analysis, and specifically reflects medical risks, not security risks ?		
4. Has it been developed in a consultative manner with the local security staff and staff association ?		
5. Have the UN clinic, UN Medical Services or WHO been involved in the devlopment of the MCIP ?		
6. Does the threats analysis include public health crises and occupational health and safety risks ?		
7. Does the assessment of likelihood correspond to probability of it happening, and when it might happen, and/or on the historical frequency of it happening		
8. Does the classification correspond to the guidance ?		
9. Does the assessment of the impact correspond to the direct medical impact, based on the severity of the injury ?		
10. Does the classification correspond to the guidance ?		
No scoring, for information : How many risks are unacceptable ? Pls specify		
No scoring, for information : How many are very high ? Pls specify		
No scoring, for information : How many are high ? Pls specify		
11. Has a "Mitigation and residual risk" analysis been performed ? By whom ?		
12. Have measures been taken to address the Unacceptable, very high and high risks ?		
No scoring, for information. Are there any residual risks ? Please specify. How have they been assessed ?		
No scoring, for information A re there any unacceptable residual risks ? Which ones ?		
13. Have measures be undertaken to address the residual risks been specified ?		
14. Have a date and method been specified to address them ?		
Health Support Summary (if applicable)		
15. Has a Health support summary been developed ?		
16. Does it cover all the critical health support assets available in the duty station ?		
17. Does it cover all field duty stations ?		
18. Are the UN clinics correctly referenced, according to the guidelines ? (if applicable)		
19. Are the hospitals correctly referenced, according to the guidelines for all duty stations ? How many ?		
20. Has the capacity of the hospitals with dealing with mass casualty been assessed ?		
21. Is there an MOU with the referral Hospitals for the implementation of the MCIP ?		
22. Are ambulance services correctly referenced, according to the guidelines ?		

23. Are there any other disaster management capabilities in the duty station, correctly referenced ?		
24. Are all medical services referenced in the plan compliant with the minimal standards, as outlined in the different forms ?		
25. Are Mortuary Services referenced ? Are there coronial services ? Autopsy capabilities ?		
26. Are are medical evacuation services correctly referenced, according to the guidelines ?		
27. Are there any local support arrangements ? Specify		
28. Are there any regional support arrangements ?		
CONOPS covering specific locations/events (if applicable)		
29. Does the MCIP include an Incident Command System ?		
30. Has a CONOPS been developed as part of the MCIP ?		
31. Does it cover all the duty stations in the country ? Which are missing ?		
32. Does it respond to the questions "Who goes where, when do they go there, and what do they do when they arrive ?"		
33. Does the MCIP include a First Responder Response Plan ?		
34. Has there been a simulation of the MCIP ? When ?		
Mass Casualty Incident *Quick Reference Guide (if applicable*		
35. Has a Quick reference guide been developed ?		
36. Does it consider both an on-site and an off-site response team ?		
37. Does it consider a senior liaison team ?		
38. Does it list the Emergency Medical Contacts, accurately with telephone numbers and alternative contacts ?		
39. Does it list the Duty station contacts ?		
40. Does it list a crisis management timeline ?		
41. Does it list ACTIONS and RESPONSIBLE for the following actions (see list and assess completeness):		
- notification and preparation to move to site		
- activities on site		
- resolution of onsite activity		
- follow up		
42. Are tasks clearly allocated with a clear chain of command ?		
43. Are key locations indicated in the QRG ? With pictures and maps ?		
44. Does it include maps of the duty station ? UN compound ? Location of offices ?		

Source :

Guide on completing MCI plan, UN MSD

Safe Hospital Checklist, WHO:PAHO

Form 6 : Medical Emergency Response

Staff Interviewed
Date
Venue

Documents :	**Yes/No**	**Comments**
UN country security plan		
Mass Casualty Incident Plan		
MEDEVAC Procedures or SOPs		
List of Medical Examining Physicians		
Updated list of contacts		
Updated list of medical facilities		
Standards	**Yes/No**	**Comments**
Country Security Plan		
1. Is there a Country Security plan (CSP) ? Has it been approved by the SMT ?		
2. Does the CSP include a Mass Casualty Incident plan (MCI) ?		
3. Has there been a first responder training programme ? When ? (if applicable)		
4. Has there been a training in basic first aid ? Who has been trained ?		
5. Does the Duty Station have an inventory of First Aid Kits ?		
6. Was the last incident requiring First Aid adequately handled with a positive outcome ?		
7. Does the Duty Station have an inventory of PEP kits ?		
8. Is there an updated list of PEP kits custodians ?		
9. Is there a list of trained practioners/counselors that can administer the PEP kits ?		
10. Has there been a training of first responders ? Who has been trained ? (if applicable)		
11. Is there a list of trained first responders ? How many are they ? (if applicable)		
12. Does the Duty Station have an inventory of Emergency Trauma Bag (ETB) equipment (if applicable)?		
13. Have first responders been trained in the use of the ETB ? (if applicable)		
14. Does the Duty Station have an inventory of Individual First Aid Kits (IFAK) (if applicable) ?		
15. Have first responders been trained in the use of the IFAK ? How many ? (if applicable)		
CASEVAC (Case evacuation from the field)		
16. Are there any modalities in place for evacuation from a field duty station to the principal duty station or the regional medical centre ?		
17. Has the SMT assessed the Medical Emergency Response capability of the duty station ?		
18. Does a clear CASEVAC procedure exist for every field duty station ? (if applicable)		
19. Have CASEVAC procedures been established with clear command, control and coordination responsibilities ?		
20. Are there clear procedures and inventory of facilities capable to provide advanced life support and damage control rescuscitation for every field station ?		
21. Are there clear procedures and inventory of facilities capable to provide damage control surgery/ ICU ?		

22. Does the CASEVAC procedure consider different scenarios (trafic accident, infectious disease, toxic exposure,…)		
23. Was the last incident requiring CASEVAC responded to within 24 h ?		
24. Did the last incident requiring CASEVAC have a positive outcome ?		
MEDEVAC (Medical evacuation to the regional referral center)		
25. Are the administrative instructions for MEDEVAC available ?		
26. Does the HOAs have the authority to authorise the MEDEVAC ?		
27. Is there an updated list of UN recognized physicians to issue the medical recommendation for the MEDEVAC ?		
28.Is the nearest recognized regional medical centre accessible within 24 h ??		
29. Is there a updated list of the points of contact at the regional medical centre ?		
30. Is there and SOP for the modalities of transport to the regional medical centre ?		
31. Is there an SOP for the autorisation of MEDEVAC by the insurance company ?		
32. Is there a centralized reporting system in the Duty Station of the MEDEVACs ?		
33. Do both National and International staff have access to MEDEVAC ?		
34. Was the last incident requiring MEDEVAC responded to within 72 h ?		
35. Did the last incident requiring MEDEVAC have a positive outcome ?		

Source :

Casualty Evacuation in the Field, Policy, UNDPKO

MEDEVAC, Administrative instructions, Un Secretariat

Guidelines on First Responder Programmes, UNDSS

Form 6 b: Assessment of Ambulance service (standalone or hospital service)

Name of facility:
Type of facility:
Registration number :
Date :
Address:

Number of staff:	**Number (full-time equivalent)**	**Comments**
Medical Doctor		
Registered Nurse		
Auxiliary Nurse		
EMC attendant		
EMC Driver		
Other:		
Infrastructure:	**Yes/No**	**Comments**
Reception area		
Garage		
Emergency Communication centre		
Storage room		
Ambulance A1 or A2 (patient transportation)		
Ambulance B (emergency ambulance Basic Life Support)		
Ambulance Type C (Mobile ICU Advanced Life Support)		
Toilet and washroom		
Cashier		
Other: Advanced support car		
Attendance	**Yes/No**	
The service attendance hours are 24/7		
If not 24/7, the services has a system for off-duty personnel on call 24/7		
Standards	**Yes/No**	**Comments**
Mandatory Standards (if not compliant, assessment stops here)		
Resuscitation services are available in each ambulance and contain at least a manual ventilator (bag mask), defibrilator and essential drugs.		
Are there minimum two ambulance personnel at all times for each ambulance ?		
Staff has been trained in Basic and Advanced Life support techniques		
Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly, when required.		
Standards		
Service Delivery		
1. Are there documented policies on administrative and technical Standard Operating Procedures (SOP)?		
2. Is there a policy on retention of records and data collection ?		
3. Does the ambulance or the service have copies of clinical protocols for most frequent cases ?		
Information management		
4. Are Hospital referral forms filled out, secured and confidential ?		

5. Is there a Logbook with name, sex and age of patient, name of physician (if applicable) origin and destination, date and time of dispatch and return, reason for transfer, dispostion of patient available and used by the crew ?		
Safety procedures		
6. Is there a SOP for desinfection and preventive maintenance of the ambulance ?		
7. Is there Personal protective equipment for the ambulance crew ?		
8. Are there SOPs for the proper disposal of infectious waste, sharps and hazardous substances ?		
Staff capabilities		
9. Is there one driver for each shift, with valid professional driving licence and first aid training ?		
10. Are the EMT attendants qualified professionals and do they benefit from regular updates and training ?		
11. Is there a staff development and continuing education programme ?		
Ambulance Body		
12. Are the external markings and lights in conformity with international standards ?		
13. Is there an internal separation of the driver from the body of the ambulance ?		
14. Are there internal grabrails and adequate and stable cabinets for storing the required equipment ?		
Equipment: Basic Life Support		
Check for the presence of the following equipment		
15. (a) one primary, elevating wheeled cot, adjustable to 2 or more levels;		
16. (b) one auxiliary stretcher or stair chair/stretcher combination;		
17. (c) one sterile maternity kit;		
18. (d) one adult bag-valve-mask resuscitator with reservoir;		
19. (e) one paediatric bag-valve-mask resuscitator with reservoir;		
20. (f) one adult traction splint and one paediatric traction splint or one combination adult/paediatric traction splint;		
21. (g) 6 extremity splints in various sizes, disposable or otherwise;		
22. (h) one portable medical oxygen system with a pressure reducing regulator, litre flow control and oxygen supply;		
23. (i) one portable suction unit;		
24. (j) one infant bulb suction in addition to any included in the sterile maternity kit;		
25. (k) one set of sandbags or a head immobilizer;		
26. (l) 2 sets of rigid cervical collars, including a minimum of 4 different sizes in each set;		
27. (m) one upper body immobilizing extrication device;		
28. (n) one bed pan;		
29. (o) one urinal;		
30. (p) 2 K-basins or self-sealing clear plastic emesis bags;		
31. (q) a sufficient number of patient care report forms;		
32. (r) one long spine board with straps;		
33. (s) one scoop stretcher with straps;		
34. (t) one sterile burn kit.		
Equipment Advanced Life Support (if applicable)		
Check for the presence of the following equipment :		
35. a) all the equipment specified under BLS of this standard		
36. b) a portable cardiac monitor/defibrillator;		

37. (c) medications, drugs, I.V. solutions and the equipment necessary for the administration of them;		
38. (d) endotracheal intubation equipment.		
Aditional equipment		
39. (a) one set of oropharyngeal airways, sizes 00 through 6;		
40. (b) one adult blood pressure set;		
41. (c) one paediatric blood pressure set;		
42. (d) one stethoscope;		
43. (e) one penlight;		
44. (f) one pair of bandage scissors or super shears;		
45. (g) a supply of sterile 4 x 4s;		
46. (h) a supply of abdominal pads or 4 x 8 dressings;		
47. (i) a supply of clean 4 x 4s;		
48. (j) a supply of roller and triangular bandages;		
49. (k) a supply of adhesive bandages;		
50. (l) a set of hand tools consisting of one combination screwdriver, one 25-cm crescent wrench, one 15-cm pair of pliers, one hammer, and one hacksaw with 3 spare blades;		
51. (m) a supply of tape.		
Comunication equipment		
52. Does the ambulance service have an installed Radio communication system (base, vehicle, handheld) ?		
53. Does the ambulance service have a dedicated telephone number and operator ?		
Backup-Supervision		
54. Does the ambulance service have a link with an ICU or emergency care unit ?		
55. Is there a Medical supervisor of the Ambulance service or a Mecical Doctor part of the team ?		
Performance		
56. Is the average time between call and arrival at the scene of the patient < 30 min ?		
57. Is the average time between call and arrival at the referral hospital < 1 h ?		

Source :

Standards of ambulance equipment and supplies» Open Government, Alberta, Canada
Ambulance services performance standards», Kern County Public Health Department, California USA.
Assessment tool for licensing land ambulance and ambulance service provider,
Department of Health, Republic of the Philippines
Prehospital Trauma Care systems, WHO,

UNMD
UNITED NATIONS MEDICAL DIRECTORS

Guideline for the assessment of the Mandatory Health Support Elements (MHSE) in a duty station

Executive Summary

The purpose of these Mandatory Health Support Elements (MHSE) self-assessment tools is to contribute to the decision making for a health support plan for a duty station, in the context of the Duty Station - Health Risk Assessment (DS-HRA). The DS-HRA is a core element of Occupational Safety and Health (OSH) to prevent or reduce occupation related injuries, illness, and death of the United Nations personnel. The purpose of a health risk assessment (HRA) in a duty station is to identify the hazards, evaluate the risks, assess the measures already in place, analyze the gaps and provide recommendations for the health support plan. An HRA enables managers to make informed decisions how to mitigate and to prioritize the health risk at the duty station, thus supports to discharge a main part of the duty of care towards the personnel in the duty station. This assessment represents the "health" component of a multidisciplinary approach launched under the umbrella of the 2016 HLCM strategic 2015-2020 planning. This work arises directly from the request of the HLCM, and its strategic focus on Duty of Care (2016).

The purpose of the assessment is to evaluate whether or not the different elements comply with the basic standards of quality care. It does not aim to perform a full assessment of the different health services used by UN staff, but to provide assurances that the managers are making the right decision in the provision of healthcare to UN staff. However, given that the roll-out of the DS-HRA could take some time, the self-assessment of the Mandatory Health Support Elements (MHSE)[1] can be also performed as a stand-alone process. In this case, the results of this process would inform the UNCT and the OMT whether the current model of care in the duty station, i.e. between fully outsourcing health care to external providers at one end, to fully provide primary care in-house, will ensure the right of UN staff to best quality health care.

After an introduction, the second chapter describes the overall outline of the process, the third chapter the strategic implications of the assessment and and the fourth chapter, the

[1] The Mandatory Health Support Elements are: (1) Primary Care, (2) Hospital Care, (3) Mental Health Services, (4) Mass Casualty Incident Plan, (5) Medical Emergency Response, (6) Access to pharmaceuticals (including PEP)

detailed instructions on the use of the tools.

The second chapter is organized in two parts. The first part consists in checking the level of quality of the health system, according to the capacity of the National Regulatory Authorities (NRA) or whether the health facilities have been assessed by another agency. In essence, if the NRA in a given country is well developed, there is no need to perform a full assessment, as one can realistically conclude the health system is complying with international standards and one can use the national reporting system to ascertain the quality of care in a given facility. Alternatively, even if the NRA is not well developed, but assessments of (parts of) the MHSE have been performed by another internationally recognized accreditation organization, like JCI, Veritas, Canada International, etc. the results of these assessments can be used instead of performing the self-assessment.

The second part of the second chapter consists in explaining the self-assessment proper, how to plan for it, what would be the sequence of steps, how to score and rank the health facilities and how to analyze the findings and develop gap analysis and risk mitigating strategy. It concludes with a list of UN preferred providers, recommended for staff to use.

The third chapter presents the strategic conclusions to be drawn from the assessment in ensuring access to quality care for UN staff.

The fourth chapter includes detailed instructions on how the tools are organized according to the following sequence of the forms: (1) Primary Health Care facility, (1b) Laboratory, (2) Referral Hospital, (3) Mental Health facility, (4) Pharmacy, (5) Mass Casualty Incident Plan, (6) Medical Emergency Response, Evacuations (including PEP kits), (6b) Ambulance services. Each instruction explains the process for each of the tools and lists the "mandatory standards" up front. The principle is that if a given facility does not comply at least with those "mandatory standards", there is no need to proceed further, as one can safely conclude the facility will be non-compliant. After that it explains how to apply the other standards, score them and checks whether the facility is fully compliant (100 % of standards) borderline (100-90%) in need for improvement (90-80%) or non-compliant (<80%). The instructions do not provide a detailed explanation of each of the indicators in part because they are seal-explanatory.

The guide ends with copies of all the self-assessment tools as well as terms of reference for the Operations Management Working Group and for a local assessor/consultant.

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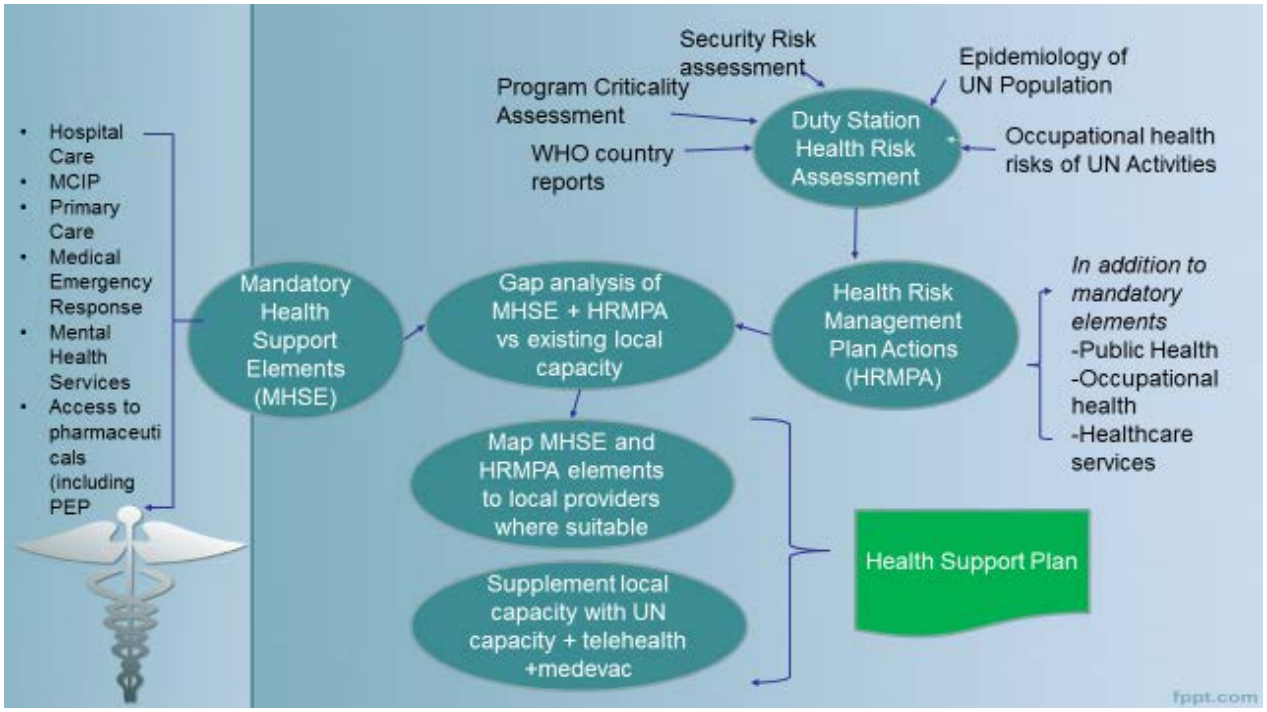
1. Introduction

1.1. Purpose

The purpose of the Mandatory Health Support Elements (MHSE) self-assessment tools is to contribute to the decision making for a health support plan, in the context of the Duty Station - Health Risk Assessment (DS-HRA). The DS-HRA is a core element of Occupational Safety and Health (OSH) to prevent or reduce occupation related injuries, illness, and death of the United Nations personnel. The purpose of a health risk assessment (HRA) in a duty station is to identify the hazards, evaluate the risks, assess the measures already in place, analyze the gaps and provide recommendations for the health support plan. An HRA enables managers to make informed decisions how to mitigate and to prioritize the health risk at the duty station, thus supports to discharge a main part of the duty of care towards the personnel in the duty station. This assessment represents the “health” component of a multidisciplinary approach launched under the umbrella of the 2016 HLCM strategic 2015-2020 planning. This work arises directly from the request of the HLCM, and its strategic focus on Duty of Care (2016).



The flowchart presents the place of the self-assessment of the Mandatory Health Support Elements (MHSE) [2] in the context of the DS-HRA. The purpose of the assessment is to evaluate whether or not the different elements comply with the basic standards of quality care. It does not aim to perform a full assessment of the different health services used by UN staff, but to provide assurances that the managers are making the right decision in the provision of healthcare to UN staff.

However, given that the roll-out of the DS-HRA could take some time, the self-assessment of the MHSE can be also performed as a stand-alone process. In this case, the results of this process would inform the UNCT and the OMT whether the current model of care in the duty station, i.e. between fully outsourcing health care to external providers at one end, to fully provide primary care in-house, will ensure the right of UN staff to best quality health care.

1.2. Audience

This guide is intended for local assessors/consultants or UN health staff tasked by the UNCT or OMT to perform the assessment of MHSE, for the UN interagency working group tasked with the oversight of that process, and also as an explanatory guide for managers, administrative officers, or other officials at duty stations who are designated with accountability for duty of care.

[2] The Mandatory Health Support Elements are: (1) Primary Care, (2) Hospital Care, (3) Mental Health Services, (4) Mass Casualty Incident Plan, (5) Medical Emergency Response, (6) Access to pharmaceuticals (including PEP)

2. Outline of the assessment process

2.1. Preliminary steps

The purpose of this first phase is to get the endorsement of the UN agencies at the duty station to perform the self-assessment of the MHSE and decide on how to implement the process. This would imply the following steps:

- present the process and get endorsement from UNCT, in the context of the DS-HRA or as a standalone process

- UNCT to give mandate to Operations Management Team (OMT) or set up a specific working group tasked with supervising the assessment (see TORs Annex 10*)*

- select a WHO staff member or contract a local assessor/consultant to perform the assessment process (see TORs Annex 11)

2.2. Initial steps of assessment

The purpose of this second phase is to decide whether the quality of the health services in the country, whether from the public or private sector, do respect international standards. More particularly, the purpose is to check whether the list of existing preferred healthcare providers meet international standards of care. If that is the case, they can be relied upon to provide access to good quality care for UN staff. Therefore, there would be little added value for the self-assessment.

A secondary purpose of this phase would be to check the quality and performance of the internal preparedness for Mass Casualty Incidents and the performance of standard operating procedures for different mandatory processes like MEDEVAC or CASEVAC.

Step 1: Check international classifications of the Country Health System

The first step would consist in assessing whether the Ministry of Health in the duty station has a strong regulatory capacity (particularly of the private sector) and thus can ensure respect of international quality standards by the health sector. The WHO office in the country should be able to advise the UNCT or OMT on this issue and provide insights in the registration, certification, inspection and accreditation process in the country. If the country can be classified as having a strong National Regulatory Authority, one can assume health services do respect international healthcare standards.

Alternatively, the working group could check if the Ministry of Health of their country is part of the ISQua (International Society for Quality in Health Care) network at https://www.isqua.org/ or any other quality network. Specifically, for the pharmaceutical sector, they could also check the list of countries with Strong Regulatory Authorities, at https://picscheme.org/en/members [3]

[3] If a country is listed in the participating authorities, the pharmaceutical sector in the country is deemed as safe

Whether or not the Ministry of Health has the capacity to control the quality of health care, the working group should check if the preferred health care providers (as provided by the OMT) have been accredited or certified by an international body of accreditation like the Joint Commission International (JCI), International SOS, CIGNA, Canada International, Veritas, etc.… and check any international standards classification of the health system (WHO Project ATLAS Mental Health, SRA/PICs for pharmaceuticals, ISQua (International Society for Quality in Health Care …)

- for the list of countries and facilities that are accredited by the JCI see [4] https://www.jointcommissioninternational.org/about-jci/jci-accredited-organizations/

- for the CIGNA provider network [5] https://www.cignahealthbenefits.com/en/healthcare-providers/provider-network (need to be member of CIGNA to check list of certified providers)

- for the International SOS network of accredited facilities, https://www.internationalsos.com/locations [6]

- for the Canada International network of accredited facilities, https://accreditation.ca/intl-fr/services-accredite-international/

- for accreditation services by Veritas International https://www.dnvgl.com/healthcare/index.html

- or the list of a macro assessment of Mental Health Services per country, see https://www.who.int/mental_health/evidence/atlas/profiles-2017/en/ [7] and for more detailed reports see https://www.who.int/mental_health/who_aims_country_reports/en/

If the country where the Duty Station is located is part of the list of countries with strong national regulatory authorities, there is no need to perform the self-assessment of MHSE. Indeed, in that case, management can be fairly confident that the quality of care provided to UN staff is corresponding to the best international standards.

If health institutions used by UN staff have been certified or accredited by one of the International Organizations, the team could use the results of these assessments instead of performing the self-assessment. However, it is unlikely that primary care practitioners or Mental Health facilities would be certified by insurance companies or accredited by an International Body. In this case, the team should perform self-assessment (only) of such facilities that have not been certified, among the preferred providers.

In any case, if all preferred providers have been certified, the team should proceed directly to the last step of the process, i.e. assess whether the MHSE are adequately addressed,

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[4] Check on the map or select in the list if your country is represented, to list accredited facilities

[5] For checking for an accredited facility, you will have to login as a CIGNA member

[6] Check the map or list to see whether your country is covered by an assistance programme. If yes, contact the local office for the availability of an assessment of the hospitals in the country (members only)

[7] These sources provide an overall picture of the availability of Mental Health Services per country but do not assess individual services. It provides a means to decide whether or not to perform a full assessment.

develop a risk mitigation plan if needed and fill in the **MHSE** Gap analysis/ Risk control tool (Annex 9)

If the information is incomplete or there is no reliable National Regulatory Authority, then it is recommended to perform the assessment as explained in 2.3.

Step 2: Desk Review

In any case, the consultant or the working group should perform a **desk review** of the following documents, to ensure that they respect the policy guidelines and there are no constraints or bottlenecks for their implementation and access:

- Country Security Plan (CSP),
- Mass Casualty Incident Plan (MCIP) (in the CSP)
- Eventually the Security Risk Management done online by DSS
- SOP and performance for MEDEVAC/CASEVAC,
- list of UN Medical Examining Physicians
- list of third-party payees accepted by the Health Insurance companies of UN staff

Previous to the desk review, it is recommended to review the Guidelines on Security Plans, UNDSS, 28 September 2018., the Guide on completing the Mass Casualty Incident Plan Templates, UNMD 6 April 2015 as well as the Administrative Instructions MEDEVAC, ST/AI/2000/10

Step 3: Interviews

If there is any doubt on the content or the quality of the documents or the performance of the SOPs, then the team should interview the DSS-SA and Field Security Officers, for assessing MCIP and Medical Evacuations (forms 5 and 6) and identifying bottlenecks. This should clarify any doubts and eventually result in developing an improvement plan. The key recommendations would also be summarized in the **MHSE** Gap analysis/ Risk control tool (Annex 9) and submitted to the UNCT.

Furthermore, in any case, it would be useful to organize a meeting with representatives of the **UN staff associations** either at the beginning of the process (to check the list of preferred providers) or after the review of accreditation or the desk review. This would serve the purpose of collecting concerns of staff on access and quality of healthcare for themselves and their dependents, identify bottlenecks and constraints in access to health care and MEDEVAC, and confirm the **list of UN preferred providers** used by staff, to check whether this corresponds to the list of preferred providers and/or facilities having a MOU with the Health Insurance companies.

Similarly, in case of doubt about the performance of MEDEVAC, the team should interview any Medical Examining Physicians (MEP) using form 6, but only for the parts referring to the case evacuations from the field to the capital city (CASEVAC) and Medical evacuations to the

regional referral center (MEDEVAC).

Step 4: Summary MHSE Gap Analysis & Risk Controls

After completing the review of the international classification of the country health care system, the desk review and eventually the interview of the DSS-SA, staff associations and MEP, the team should discuss the different parts of the assessment, review the constraints and bottlenecks, and eventually define risk mitigating strategies. On this basis, they should complete the summary MHSE Gap Analysis and Risk Control table (Annex 9) and use it to debrief the UNCT/OMT.

The final outcome of this process will be for the UNCT to confirm the model of care in the country, i.e. outsourcing of the majority of health services. Furthermore, this process will result in confirming the list of preferred providers.

As an example, please find below the summary table for the Kathmandu, Nepal Duty Station:

MHSE Gap Analysis (Nepal) & Risk Controls										
	Element Description	Residual Risk Score	Recommended risk controls (joint recommendations from HRA and MSD)	Local Provider available and accessible as needed?	If not/partially covered, can current UN capacity compensate?	describe basis for rating.	MHSE appropriately addressed ?	Actions needed to fully implement Mandatory Health Support Elements	Projected RR Score	Risk Controller
Mandatory Health Support Elements (MHSE),	Primary Care	n/a	n/a	Yes	n/a		yes		n/a, mandatory	RC & MSD
	Hospital Care	n/a	n/a	Yes	n/a	2 identified hospitals-Grande and Norvick- are suitable for this Health Support Element	partial	Procurement & RC to take action to finalize MOU with the 2 hospital providers identified as suitable	n/a, mandatory	RC & Procurement
	Mental Health Services	n/a	n/a	no	No	Appropriate inpatient care is not available and would need evacuation; Outpatient services are very limited and confidentiality is a significant issue (admittedly so by MH professionals locally).	No	Identify nearest med eval centres for MH inpatient needs; Confidential MH services are also a challenge in this culture so online resources such as telepsychiatry would be a good option for outpatient services.	n/a, mandatory	RC and Country Team HR leads.
	Mass Casualty Plan	n/a	n/a	Partial	yes	MCP should be built according to the available resources	partial	UNMERT can assist in draft of medical component of the MCIP	n/a, mandatory	Chief Security Advisor
	Medical Emergency Response	n/a	n/a	Partial	No	External providers available and suitable, but currently no contractual relationship with UN.	No	MOU with ambulance companies with skilled paramedics	n/a, mandatory	RC & Procurement
	Access to pharmaceuticals	n/a	n/a	Partial	Yes	External providers available and suitable, but currently no contractual relationship with Cigna/UN insurance	No	Health Insurance Company to visit Nepal and set up proper service agreements	n/a, mandatory	RC
	PEP	n/a	n/a	Yes	n/a	PEP activities in place	yes	Continue with PEP and assure that any onboarded UNEPs are fully trained.	n/a, mandatory	RC

2.3. Self-assessment proper

In the case the country does not comply with international standards or assessments by other organizations are not available, then the team or the consultant should implement a full self-assessment process. This would consist of the following steps:

Step 1: Preliminary Interviews

- Interview the Operations Management Team (**OMT**) or anybody in charge of supervising health care for staff, on their perception of the quality of the MHSE and any bottlenecks or constraints

- Interview the **WHO** Representative or the staff in charge of Health Systems on the quality of healthcare in the country and how this affects access to the MHSE for UN Staff

- organize a meeting with representatives of the **UN staff association**. This would serve the purpose of collecting concerns of staff on access and quality of healthcare for themselves and their dependents, identify bottlenecks and constraints in access to health care and

MEDEVAC, and confirm the **list of UN preferred providers** used by staff, basis for the assessment.

The format of the interviews should be a participatory dialogue where the team or the consultant should take care to act as a facilitator in order not to influence the results. The guiding questions for these interviews could be the following:

- What is your assessment of access to health care in general for yourself and family?
- What are the main health problems staff face in the country?
- Are those problems being addressed adequately at the moment?
- When you or your self are sick, where do you consult in first resort? What is your assessment of the quality of care? What are the concerns, constraints, problems, etc.?
- When you need to be referred to a hospital for additional exams or you need to be hospitalized, which facility do you use? What is your assessment of the quality of care? What are the concerns, constraints, problems, etc.?
- When you need to buy medecines, where do you purchase them? What is your assessment of the quality of care? What are the concerns, constraints, problems, etc.?
- Do you have you any knowledge of a recent case where a colleague, or even yourself, had to be evacuated (MEDEVAC)? How was the experience? What are the concerns, constraints, problems, etc.? What was the outcome?

Care should be taken to perform this process not only for the main office in the capital, but also for any field duty stations.

Step 2: Assessment of MCIP and Medical Emergency Response

If not performed before, interview **the DSS-SA** and Field Security Officers (for all field duty stations), for assessing MCIP and Medical Evacuations (forms 5 and 6) and identifying bottlenecks. The reason for performing this interview before the visits to the facilities is to fine tune the list of UN preferred providers and draw the attention to certain critical issues to observe during the visits.

Similarly, the team should interview any Medical Examining Physicians (MEP) responsible for authorizing MEDEVAC, using form 6, but only for the parts referring to the case evacuations from the field to the capital city (CASEVAC) and Medical evacuations to the regional referral centre (MEDEVAC).

Step 3: Compile the list of health providers to assess, planning of visits

Based on the 2 previous steps and the list of approved UN providers, compile the list of providers to assess in the main duty station and field offices. These facilities should cover the following elements of the MHSE:

- Primary Health care facilities or General Practitioners, using Form 1
- Stand-alone Laboratories, if used by staff, using Form 1b

- Referral Hospital, including laboratory, pharmacy, surgery and ICU, using form 2 [8]
- Mental Health facilities, using form 3
- Stand-alone Pharmacies, using form 4
- Ambulance services, using form 6b

In countries with a large number of agencies and/or field offices, it would clearly be very difficult to assess ALL health providers of UN staff. In this case, it may be useful to concentrate the assessment on a sample of providers, selected on the basis of attendance by staff.

After the selection of the health providers, the team should then send official requests for visiting the facility to all selected facilities, explaining the purpose of the assessment, share in advance the forms (according to the facility) and schedule a programme of work.

Steps 1 to 3 can be completed in less than a week, including sending invitations and set up the work schedule, in the case of a single location.

In the case there are several Field Duty Stations in the country, two options are possible:

- if there is a limited number of Field offices (i.e. less than 5), it would make more sense to have the same consultant visit them all. In this case, s/he could combine the previous steps with the assessment proper, and only request the list of health providers from the FO's for planning purposes.

- in the case there are many FO's (i.e. more than 10), or the FO's are very large, one alternative is to contract one consultant per FO, to be coordinated by the working group or a lead consultant.

Whether to choose one or the other option would depend on the specific context of each duty station such as availability of consultants, communication, transport, number of facilities to visit, etc. Each duty station should balance time needed for the implementation of the full assessment with efficiency and consistency of the assessments. Having a single consultant implement all the assessments will be more efficient and consistent but would take more time if a large number of field offices have to be covered.

Step 4: Perform assessment proper

For assessing the different health providers, the forms are provided, with specific guidelines for each form in part 4 of this guide. The process is the same for forms 1 to 4 and 6b:

- collect the general information about the facility, including the official registration number

- collect the information about the staffing of the facility in full-time equivalent staff, i.e. 40h per week

- collect information about the infrastructure of the facility. This should be complemented by direct observation if possible.

[8] Use form 1b if there is a need for an in depth assessment of the laboratory and form 4 for the pharmacy.

- collect information about attendance hours

- assess the compliance of 3 to 5 «Mandatory standards». If the facility does not comply with these standards, the assessment should stop here. Indeed, if the facility does not comply with these basic, critical standards, it is unlikely it will pass the test with other and will thus not be scored as compliant.

- assess the compliance with the other standards and complement with direct observation, if possible and where applicable.

The total time needed for this step will depend mostly on the number of providers and facilities to assess. The time to implement each form in a given facility will be indicated in the specific instructions for each form in part 4 of this guide.

Step 5: Compile scoring of providers

Each facility should be scored according to compliance with standards. Please note the staffing, infrastructure and attendance are not to be included in the scoring.

The scoring should calculate the percentage of indicators compliant with standards related to the total number of **applicable** indicators.

The following scoring thresholds are suggested:

- 100% of applicable indicators meet standards, fully compliant
- 90 – 100%, of applicable indicators meet standards, satisfactory, but need to be monitored
- 80 – 90 %, of applicable indicators meet standards, borderline, but need an improvement plan
- < 80%, of applicable indicators meet standards, non-compliant

Step 6: Ranking of facilities according to compliance.

Once all assessments have been completed and each individual facility scored for compliance, the facilities should be ranked, for each element of the MHSE. The ranking should be done according to the same thresholds as the individual scoring. These lists will form the basis for the crucial next step of assessing the overall quality of the MHSE and defining a risk control strategy.

Step 7: Define risk control strategies if needed

With the working group, agree on the list of compliant providers or discuss alternative strategies (UN clinic, UN nurse, Outsourcing…) or improvement plans.

Basically, for each element of the MHSE, three outcomes are possible: the element is adequately addressed, partially or not at all.

In the first case, the element is **adequately addressed**, if all the facilities for a given element are compliant with standards. In this case, no further action is required, and the working

group can recommend to the UNCT to outsource fully health services for that element.

In the second case, if the element is **partially addressed,** a risk control strategy is required. This could consist either in complementing the system element with UN driven solutions like a UN Nurse, a UN Clinic, etc. Another option is to request improvement plans from the facilities that are borderline or put in place alternative strategies like telemedicine or increased MEDEVAC.

In the last case, if the **element is not addressed** at all, the only options would be to recommend strengthening or implementing a UN clinic, develop telemedicine alternatives and increase MEDEVAC/CASEVAC. In the case no alternative exists, particularly for emergencies, it is recommended to actively develop a risk control strategy, in partnership with the providers, adressing the weaknesses identified during the assessment, so as to ensure duty of care for UN staff.

Step 8: Summarize findings

At the end of the exercise, the team should consolidate the findings in the MHSE Gap Analysis and Risk Controls Summary table (see below and Annex 9) and present the conclusions and recommendations to the OMT and UNCT. Please note the pre-selection of yes, no, partial and not applicable (n/a) which are pre-colour coded to give an immediate overview of status.

UNMD	MHSE Gap Analysis & Risk Controls						
Duty Station:		**Local Provider available and accessible as needed?**	**If not/partially covered, can current UN capacity compensate?**	**describe basis for rating.**	**MHSE appropriately addressed?**	**Actions needed to fully implement Mandatory Health Support Elements**	**Risk Controller**
	Element Description						
Mandatory Health Support Elements (MHSE)	**Primary Care**	yes	no		yes		
	Hospital Care	partial	n/a		no		
	Mental Health Services				partial		
	Mass Casualty Plan				n/a		
	Medical Emergency Response						
	Access to pharmaceuticals, incl. PEP						

Timing of the assessment

The time needed for a full assessment would obviously depend on the number of facilities and the number of field offices visited. However, the following is an indicative list of time needed for the different steps:

1. Preliminary interviews: 3 to 5 h

2. Assessment of MCIP and Medical evacuations: 2 to 6 h for one duty station, depending on the number of MEPs

3. Compile list and planning: 1 day

4. Assessment of the facilities and scoring: minimum 8 h, if one single facility of each type in a given duty station, otherwise, according to number of facilities

5. Ranking, Risk mitigation strategies and summarize finding: 1 day

3. Conclusions

3.1. Local Healthcare Capability Assessment

Following the MHSE Gap Analysis and Risk Controls, the working group or the OMT should identify which parts of the mandatory health support elements can be safely outsourced to reputable local providers. Further to the results of the assessments, the team should consider the following criteria:

- Accessibility (wait-time for appointments/admission and acceptance of UN health insurance) and the level of qualifications of key medical personnel who are providing services at the facility.
- Safe: Avoiding harm to patients from the care that is intended to help them and ensuring that procedures are in place to give assurances that only qualified personnel are delivering services.
- Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding under-use and misuse, respectively).
- Patient-centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

3.2. Consideration of variety of models of care

A model of care is a method for delivering healthcare. This can be traditional (e.g. a doctor's clinic), or innovative – (e.g., telehealth). Both mode of delivery and responsible personnel can be flexibly considered when making recommendations to deliver the lowest cost, most effective care.

The final outcome of the self-assessment will be to advise the OMT and UNCT on the model of care for the provision of health care to UN staff. Some examples of models of care to

deliver the requirement for Primary Care include:

- Use local external providers exclusively.
- Use local external providers, but also have a nurse internally, who knows local providers and can assist staff to navigate system
- Use local external providers, but also have a medical doctor internally
- Consider complementing the services of the nurse and/or the medical doctor with the provision of essential medicines
- Have a UN Clinic that delivers all primary care except mental and women's health, and outsource those
- Have a UN clinic that delivers all primary care, etc.

A decision to resource healthcare internally (e.g. through a UN clinic, and occupational health nurse, or by the WHO Office) should only be taken after consideration of the risk profile and the mandatory health support elements, how effectively the local external resources mitigate that risk (gap analysis), and whether adding an internal UN health resource would have a significant impact on key risks.

4. Detailed instructions on the use of the forms

4.1. Assessment of Primary Care Facility (form 1)

This form could be used to assess a medical clinic, a UN clinic, an outpatient facility of a general hospital or a health center. **Time needed for each facility: approx. 1 h**

Process:

- Select the **focal point** to be interviewed: ideally it should be the head physician of the facility. If not available, the manager

- fill in the **generic information** about the facility

- Inquire about the different type of **staff** and fill in the information, taking in account full-time equivalent staff (i.e. 40 h per week)

- request information about **infrastructure** and **observe** state of cleanliness, comfort, safety, furniture, etc. during the visit after the interview

- request information about **attendance** hours of the clinic

- interview focal point on compliance with **mandatory standards**:

    - Staff has been trained in Basic and/or Advanced Life support techniques

    - Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly, when required.

    - Does the clinic have a practitioner trained in Basic Gynecological and obstetrical care (ANC, pregnancy monitoring, contraception, preventive care, etc.)

If the facility does not comply with these basic standards, it should be considered as non-compliant and assessment would stop here

- interview focal point on **compliance with the other standards,** using a simple pass/fail, Yes/No system. Add comments for each indicator if needed, but particularly if not compliant.

- as much as possible request **proof of veracity of the indicators** that refer to written guidelines, record keeping, equipment, infrastructure, either through direct observation or copies of the documents

- **compile the score**: by calculating the number of indicators with positive response / total number of applicable indicators as a percentage[9]

- **score the facility**:

  - 100%, fully compliant

  - 90 – 100%, satisfactory, but need to be monitored

  - 80 – 90 %, borderline, need an improvement plan

  - < 80%, non-compliant

4.2. Assessment of Laboratory (form 1b)

This form could be used to assess a stand-alone Laboratory or to perform an in-depth assessment of a hospital laboratory. **Time needed for each facility: approx. 1 h**

Process:

- Select the **focal point** to be interviewed: ideally it should be the head biologist of the facility. If not available, the manager

- fill in the **generic information** about the facility

- Inquire about the different type of **staff** and fill in the information, taking in account full-time equivalent staff (i.e. 40 h per week)

- request information about the **type of analysis** performed in the facility and observe the state of equipment, maintenance, date of purchase, cleanliness, etc... during the visit after the interview

- request information about **infrastructure** and **equipment** and **observe** state of cleanliness, comfort, safety, date of purchase, furniture, etc. during the same visit

- request information about **attendance** hours of the laboratory

- interview focal point on compliance with **mandatory standards**:

  - A qualified individual(s) is responsible for managing the clinical laboratory service or pathology service.

  - All equipment and medical technology used for laboratory testing undergoes a regular internal and external quality control/calibration process

If the facility does not comply with these basic standards, it should be considered as non-compliant and assessment would stop here

[9] Please note the staffing, infrastructure and attendance are not to be included in the scoring.

- interview focal point on **compliance with the other standards,** using a simple pass/fail, Yes/No system. Add comments for each indicator if needed, but particularly if not compliant.

- as much as possible request **proof of veracity of the indicators** that refer to written guidelines, record keeping, equipment, infrastructure, either through direct observation or copies of the documents

- **compile the score**: by calculating the number of indicators with positive response / total number of applicable indicators as a percentage [10]

- **score the facility**:

  - 100%, fully compliant
  - 90 – 100%, satisfactory, but need to be monitored
  - 80 – 90 %, borderline, need an improvement plan
  - < 80%, non-compliant

4.3. Assessment of Referral Hospital (form 2)

This form could be used to assess a level 1 hospital or specific services of a referral hospital. If need be, complement this process with the assessment of the Laboratory (Form 1b), the Mental Health Services (Form 3) or the Pharmacy (Form 4). **Time needed for each facility: approx. 2 h**

Process:

- Select the **focal point** to be interviewed: ideally it should be the head doctor of the hospital, but most likely it will be the manager

- fill in the **generic information** about the facility

- Inquire about the different type of **staff** and fill in the information, taking in account full-time equivalent staff (i.e. 40 h per week)

- request information about **infrastructure** and **observe** state of cleanliness, comfort, safety, furniture, etc. in a sample of them during a visit after the interview.

- request information about **attendance** hours of the clinic

- interview the focal point on compliance with **mandatory standards**:

  - Resuscitation services are available throughout the hospital and contain at least a manual ventilator (bag mask), defibrillator and essential drugs.
  - Staff has been trained in Basic and/or Advanced Life support techniques
  - Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly, when required.
  - A qualified individual(s) is responsible for managing the clinical laboratory service or pathology service.

[10] Please note the staffing, infrastructure and attendance are not to be included in the scoring.

- A qualified radiologist is available for interpreting results of the exams on site or through tele-consultation or on call

- Is there a business continuity system in place in the case the ICU specialist is not available?

- Does the hospital have a practitioner trained in Comprehensive Gynecological and emergency obstetrical care (ANC, pregnancy monitoring, complicated deliveries, contraception, preventive care, etc.)

If the facility does not comply with these basic standards, it should be considered as non-compliant and assessment would stop here

- interview focal point on **compliance with the other standards,** using a simple pass/fail, Yes/No system. Add comments for each indicator if needed, but particularly if not compliant.

- inasmuch as possible request **proof of veracity of the indicators** that refer to written guidelines, record keeping, equipment, infrastructure, either through direct observation or copies of the documents

- **compile the score**: by calculating the number of indicators with positive response / total number of applicable indicators, as a percentage [11]

- **score the facility**:

  - 100%, fully compliant

  - 90 – 100%, satisfactory, but need to be monitored

  - 80 – 90 %, borderline, need an improvement plan

  - < 80%, non-compliant

4.4. Assessment of Mental Health Services (form 3)

This form could be used to assess a mental health clinic or an outpatient facility of a general hospital or a health center. **Time needed for each facility: approx. 1 h**

Process:

- Select the **focal point** to be interviewed: ideally it should be the head physician or lead psychologist of the facility. If not available, the manager

- fill in the **generic information** about the facility

- Inquire about the different type of **staff** and fill in the information, taking in account full-time equivalent staff (i.e. 40 h per week)

- request information about **infrastructure** and **observe** state of cleanliness, comfort, safety, furniture, etc. during the visit after the interview

- request information about **attendance** hours of the clinic

[11] Please note the staffing, infrastructure and attendance are not to be included in the scoring.

- interview focal point on compliance with **mandatory standards**:

  - Service users can consult with a psychiatrist (or a medical doctor with at least 2 years of psychiatric training) or a psychologist (or occupational therapist) when they wish to do so

  - The following psychotropic medication is available, at all times in sufficient quantity, including pediatric formulations: 1 psychotropic, 1 antidepressant, 1 anti-anxiety, 1 anti-parkinsonian for side effects, 1 Anti-epileptic, 1 bipolar disorder drug (mood stabilizer)

If the facility does not comply with these basic standards, it should be considered as non-compliant and assessment would stop here

- interview focal point on **compliance with the other standards,** using a simple pass/fail, Yes/No system. Add comments for each indicator if needed, but particularly if not compliant.

- inasmuch as possible request **proof of veracity the indicators** that refer to written guidelines, record keeping, equipment, infrastructure, either through direct observation or copies of the documents

- **compile the score**: by calculating the number of indicators with positive response / total number of applicable indicators as a percentage [12]

- **score the facility**:

  - 100%, fully compliant

  - 90 – 100%, satisfactory, but need to be monitored

  - 80 – 90 %, borderline, need an improvement plan

  - < 80%, non-compliant

4.5. Assessment of Pharmacy (form 4)

This form could be used to assess a stand-alone pharmacy or the pharmacy of a general hospital or a health center. **Time needed for each facility: approx. 30 min**

Process:

- Select the **focal point** to be interviewed: ideally it should be the pharmacist of the facility. If not available, the manager

- fill in the **generic information** about the facility

- Inquire about the different type of **staff** and fill in the information, taking in account full-time equivalent staff (i.e. 40 h per week)

- request information about **infrastructure** and **observe** state of cleanliness, comfort, safety, furniture, etc. during the visit after the interview

- request information about **attendance** hours of the clinic

[12] Please note the staffing, infrastructure and attendance are not to be included in the scoring.

- interview focal point on compliance with **mandatory standards**:
    - Is the pharmacy licensed with the national Regulatory Authority (NRA)?
    - Has the pharmacy been inspected within the last six months by the NRA
    - Is the pharmacist registered by the National Order of Pharmacists or similar body?
    - Is there a trained pharmacist or nurse or pharmacy assistant present at all times?

If the facility does not comply with these basic standards, it should be considered as non-compliant and assessment would stop here

- interview focal point on **compliance with the other standards,** using a simple pass/fail, Yes/No system. Add comments for each indicator if needed, but particularly if not compliant.

- inasmuch as possible request **proof of veracity of the indicators** that refer to written guidelines, record keeping, equipment, infrastructure, either through direct observation or copies of the documents

- **compile the score**: by calculating the number of indicators with positive response / total number of applicable indicators as a percentage [13]

- **score the facility**:
    - 100%, fully compliant
    - 90 – 100%, satisfactory, but need to be monitored
    - 80 – 90 %, borderline, need an improvement plan
    - < 80%, non-compliant

4.6. Mass Casualty Incident Plan (form 5)

For assessing the quality and effectiveness of this plan, the team should refer to the Guide on implementing MCI plans, UNMD, April 2015 (Annex 12). The form can be used either with the SMT and DSS staff, for assessing the MCI, but also with the staff association or the Medical Examining Physician (MEP). **Time needed for each interview: approx. 1 h**

Process

- Check the availability of following **documents** and information and perform a **desk review** before any interview

- Mass Casualty Incident Plan (In the Country Security Plan)
- CONOPS
- MCI Quick reference guide
- Medical Examining Physician (MEP) name(s) and contact(s)
- List of first responders, first aid trainees
- Inventory of first aid kits, Emergency Trauma Bags, etc...
- Inventory of Ambulance services and Aero Ambulances list and contacts at duty

[13] Please note the staffing, infrastructure and attendance are not to be included in the scoring.

station and field offices
- List of hospitals with emergency care /ICU capacity

- **select** the persons to be interviewed:
  - Designated Official or DSS-SA
  - Medical Examining Physician (MEP) or UN Medical Doctor
  - (National authorities of the Police, Army, Fire Brigade, Reference Hospitals if possible)
- **Review the MCIP** as relating to the Medical threat analysis, part 1 of form 5
- **Review the risks**, mitigation strategy and residual risks, according to risk scores (unacceptable, very high, high)
- Review the **Health Support Summary**, if available, part 2 of form 5
- Review **CONOPS**, if available, part 3 of form 5
- Review **MCI Quick Reference Guide** if available, part 4 of form 5
- **compile the score**: by calculating the number of indicators with positive response / total number of applicable indicators as a percentage
- Perform **scoring** of the plan:
  - 100% of applicable indicators meet standards, fully compliant
  - 90 – 100%, of applicable indicators meet standards, satisfactory, but need to be monitored
  - 80 – 90 %, of applicable indicators meet standards, borderline, but need an improvement plan
  - < 80%, of applicable indicators meet standards, non-compliant

4.7. Medical Emergency Response (form 6)

For assessing the quality and effectiveness of this plan, the team should refer to the Guide on implementing MCI plans, UNMD, April 2015 (Annex 12) as well as the MEDEVAC, Administrative instructions, UN Secretariat (Annex 13). The form can be used either with the SMT and DSS staff, for assessing the MCI, but also with the staff association or the Medical Examining Physician (MEP). This assessment can be complemented eventually by the assessment of ambulance services, if there is any doubt about the capacity of the National Regulatory Authority. **Time needed for interview: approx. 2 h.**

Process

- **Check** availability of following **documents** and information
  - Mass Casualty Incident Plan (In Country Security Plan)
  - Duty Station Case evacuation from the field (CASEVAC) instructions (In Country Security Plan or SOP)
  - Duty station MEDEVAC instructions (in Country Security plan or SOP)

- Medical Examining Physician (MEP) name(s) and contact(s)
- List of first responders, first aid trainees, if available
- Inventory of first aid kits, Emergency Trauma Bags, etc… if available
- Inventory of Ambulance services and Aero Ambulances list and contacts at duty station and field offices
- List of hospitals with emergency care /ICU capacity

- **select** person to be interviewed:
  - Designated Official or DSS-SA,
  - MEP or UN Medical Doctor
  - Responsible Ambulance service or CASEVAC/MEDEVAC organization

- **Review MCIP**, as relating to medical emergency evacuations because of road accident, trauma or security issue, part 1 of form 6 and document latest security issue

- Review **CASEVAC** instructions or SOP, part 2 of form 6 and document latest CASEVAC episode

- Review **MEDEVAC** instructions, part 3 of form 6 and document latest MEDEVAC episode

- Check the **Inventory of Road and Air Ambulance services** at Duty station and Field Offices, and eventually, for each ambulance, perform assessment using form 6b

- Check if **referral facility** in the list of UN registered hospitals, and if Emergency/ICU capacity has been assessed.

- **compile the score**: by calculating the number of indicators with positive response / total number of applicable indicators as a percentage

- **Perform scoring**
  - 100% of applicable indicators meet standards, fully compliant
  - 90 – 100%, of applicable indicators meet standards, satisfactory, but need to be monitored
  - 80 – 90 %, of applicable indicators meet standards, borderline, but need an improvement plan
  - < 80%, of applicable indicators meet standards, non-compliant

4.8. Assessment of Ambulance services (form 6b)

This form could be used to assess a stand-alone ambulance service, the ambulance service of a general hospital or a medical air ambulance. This assessment is not needed in case there is a strong National Regulatory Authority or for International SOS services. **Time needed for each service: approx. 1 h**

Process:

- Select the **focal point** to be interviewed: ideally it should be the medical doctor in charge

of the emergency service. If not available, the manager.

- fill in the **generic information** about the service

- Inquire about the different type of **staff** and fill in the information, taking in account full-time equivalent staff (i.e. 40 h per week)

- request information about **infrastructure** and **equipment** and **observe** state of cleanliness, comfort, safety, furniture, date of purchase and expiry, etc. during the visit after the interview

- request information about **attendance** hours of the service

- interview focal point on compliance with **mandatory standards**:

    - Resuscitation services are available in each ambulance and contain at least a manual ventilator (bag mask), defibrillator and essential drugs.

    - Are there minimum two ambulance personnel at all times for each ambulance?

    - Staff has been trained in Basic and Advanced Life support techniques

    - Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly, when required.

If the facility does not comply with these basic standards, it should be considered as non-compliant and assessment would stop here

- interview focal point on **compliance with the other standards,** using a simple pass/fail, Yes/No system. Add comments for each indicator if needed, but particularly if not compliant.

- in as much as possible request **proof of veracity the indicators** that refer to written guidelines, record keeping, equipment, infrastructure, either through direct observation or copies of the documents

- **compile the score**: by calculating the number of indicators with positive response / total number of applicable indicators as a percentage [14]

- **score the facility**:

    - 100%, fully compliant

    - 90 – 100%, satisfactory, but need to be monitored

    - 80 – 90 %, borderline, need an improvement plan

    - < 80%, non-compliant

[14] Please note the staffing, infrastructure and attendance are not to be included in the scoring.

Annexes

Annex 1: Assessment of Primary Care Facility (form 1)

Form 1: Assessment of Primary Care Facility

Name of facility:
Type of facility:
Registration number:
Date
Address:

Number of staffs:	**Number (Full-time equivalent)**	**Comments**
Medical Doctor GP		
Paediatrician		
Registered Nurse:		
Auxiliary Nurse		
Laboratory Assistant:		
Radiologist		
Pharmacist:		
Physiotherapist		
Receptionist:		
Other:		
Infrastructure:	**Yes/No**	**Comments**
Waiting room		
Reception area		
Consultant room		
Small Surgery room		
Dressing room		
Pharmacy		
Laboratory		
X-ray room		
Vaccination room		
Toilets		
General storage		
Refrigerated storage for vaccines and drugs		
Ambulance		
Other:		
Attendance	**Yes/No**	
The clinic attendance hours are at least 8h per day, 5 days a week		
The clinic has a system for off-duty physician on call 24/7		

Standards	Yes/No	Comments
Mandatory Standards (if not compliant, assessment stops here)		
Staff has been trained in Basic and/or Advanced Life support techniques		
Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly, when required.		
Does the clinic have a practitioner trained in Basic Gynaecological and obstetrical care (ANC, pregnancy monitoring, contraception, preventive care, etc.)		
UN International Patient Safety Goals		
1. The clinic has a process to improve accuracy of patient identification (if applicable)		
2. The clinic has a process to ensure that all orders are written		
3. The clinic has a process for reporting critical results of diagnostic tests.		
4. The clinic has a process for handover communication.		
Data management		
5. The clinic has an in-house ethical code signed by medical practitioners		
6. Information privacy, confidentiality, and security, including data integrity, are maintained.		
7. Records and information are protected from loss, destruction, tampering, and unauthorized access or use.		
8. The medical record contains sufficient information to identify the patient, to support the diagnosis, to justify the treatment, and to document the course and results of treatment		
9. The clinic has a protocol regarding those who are authorized to make entries in the patient clinical record.		
Clinical Focused Standards		
Clinical Assessment		
10. An initial assessment/screening process is used to identify the healthcare needs of all patients.		

11. All outpatients are screened for pain and assessed when pain is present.		
12. Children are systematically assessed for fever		
13. Clinical guidelines and pathways based on WHO standards are used to support consistency in care.		
14. The care provided to each patient is planned, revised when indicated by a change in the patient's condition and documented in the patient record.		
15. Clinical and diagnostic procedures and treatments performed, and the results or outcomes, are documented in the patient's record.		
16. The care of high-risk patients are guided by professional practice guidelines.		
17. Clinical staff is trained to recognize and respond to changes in a patient's condition.		
19. Patient follow up instructions are given in a form and language the patient can understand.		
20. Patient education and instruction are related to the patient's continuing care needs.		
Pharmaceuticals		
21. The clinic implements a uniform process for prescribing patient orders.		
22. If the clinic has a pharmacy, it is stocked with sufficient quantity and variety of essential emergency drugs, according to the National Essential Drug list		
23. Medications are properly and safely stored (if applicable)		
Referral – MEDEVAC		
24. The clinic has a process to refer patients to other healthcare settings to meet their continuing care needs.		
25. The clinic carries out processes to provide continuity of patient care services in the clinic and coordination among health care practitioners.		
26. The referring clinic follows procedures for the medevac of patients to ensure they patients are transferred safely.		

27. The receiving hospital is given a written summary of the patient's clinical condition and the interventions provided by the referring clinic.		
28. The medevac process is documented in the patient's record.		
Administration-Focused Standards		
29. The clinic follows an adverse event reporting process.		
30. Patient satisfaction is monitored systematically.		
Safety		
31.The clinic adopts and implements WHO guidelines for Hand Hygiene and Universal Precautions in Health Care to reduce the risk of health care-associated infections		
32. All patient and staff areas of the clinic are included in the infection prevention and control program.		
33. The clinic tracks infection risks, infection rates, and trends in healthcare associated infections to reduce the risks of those infections.		
34. The clinic reduces the risk of infection through proper disposal of biomedical waste.		
35. The clinic implements practices for safe handling and disposal of sharps and needles.		
36. The clinic controls the use of hazardous materials and biomedical equipment.		
37. There is an SOP and equipment to ensure that all occupants of the clinic are safe from fire, smoke and other emergencies.		
38. Safe drinking water and electrical power are available during hours of clinic operation to meet essential patient care needs.		

Source:
UN Manual for Healthcare and Patient Safety in UN-Clinics, DPKO, draft 2018

Annex 2: Assessment of Laboratory (form 1B)

Form 1 B Assessment of Laboratory

(standalone or hospital laboratory) **Name of facility:** **Type of facility:** **Date:** **Registration number:** **Address:**		
Number of staffs:	**Number**	**Comments**
Medical Doctor		
Biologist		
Laboratory Assistant:		
Receptionist, admin		
Other:		
Services		
Haematology		
Microbiology/Parasitology		
Bioquimical/Serology		
Hormonal		
Culture Antibiogram		
Microscopy		
Infrastructure:	**Yes/No**	**Comments**
Waiting room		
Reception area		
Sampling taking room		
Toilets		
General storage		
Other: generator, refrigerators, etc.		
Attendance	**Yes/No**	
The lab attendance hours are at least 8h per day, 5 days a week		
The lab has a system for off-duty analysis on call 24/7		
Standards	**Yes/No**	**Comments**
Mandatory Standards (if not compliant, assessment stops here)		
A qualified individual(s) is responsible for managing the clinical laboratory service or pathology service.		
All equipment and medical technology used for laboratory testing undergoes a regular internal and external quality control process/calibration		
UN International Patient Safety Goals		
Patient Identification		
1. The laboratory has a process to improve accuracy of patient identification.		
Improve Effective Communication		
2. The laboratory has a process to ensure that all orders are written.		

3. The laboratory has a process for reporting critical results of diagnostic tests and critical events.		
Reduce the Risk of Health Care-Associated Infections		
4. The laboratory implements WHO Guidelines for Hand Hygiene and Universal Precautions in Health Care to reduce the risk of healthcare–associated infections.		
Clinical Focused Standards		
Access to Care (UNAC)		
5. At admission, patients receive information on the exams and procedures		
6. All laboratory staff members have the required education, training, qualifications, and experience to administer and perform laboratory tests and interpret the results, as per national standards.		
7. The laboratory uses a coordinated process to reduce the risks of infection because of exposure to bio-hazardous materials and waste.		
8. All equipment and medical technology used for laboratory testing is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.		
9. Clinical and diagnostic procedures and the results or outcomes, are documented in the patient's record.		
Patient and Family Education		
10. Patients and, when appropriate, their families receive education they can understand to support their participation in their care (for example, granting consent).		
Administration-Focused Standards		
Prevention and Control of Infections		
11. The laboratory reduces the risk of infection through proper disposal of biomedical waste.		
12. The laboratory implements practices for safe handling and disposal of sharps and needles.		
13. Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly, when required.		
Facility Management and Safety		
14. There is an SOP and equipment (fire alarm, extinguishers) to ensure that all occupants of the laboratory are safe from fire, smoke and other emergencies.		
15. There is an organized program for the safe management of biomedical equipment		
16. Safe drinking water and electrical power are available 24 hours a day, seven days a week, through regular or alternate sources, to meet essential patient care needs.		

17. The laboratory developed, maintains, and tests an emergency management program to respond to emergencies and natural or other disasters according to the national emergency preparedness plan.		
Staff Health and Safety		
18. There is a program to reduce health hazards for staff and to provide safe working conditions		
Management of Information		
19. Information privacy, confidentiality, and security, including data integrity, are maintained		
20. Records and information are protected from loss, destruction, tampering, and unauthorized access or use (backup or hard copy)		
21. The medical record contains sufficient information to identify the patient, the procedures and the results		
22. The laboratory has a protocol regarding those who are authorized to make entries in the patient clinical record.		

Sources:
UN Manual for Healthcare Quality and Patient Safety, Draft 2018, DPKO

Annex 3: Assessment of Referral Hospital (form 2)

Form 2: Assessment of Referral Hospital

Name of facility:
Type of facility:
Registration number:
Date:
Address:

Number of staffs:	**Number**	**Comments**
Medical Doctor GP		
Paediatrician		
Surgeon		
OB/GYN		
Internist		
Anaesthetist		
Other:		
Registered Nurse:		
Auxiliary Nurse		
Laboratory Assistant:		
Radiologist		
Pharmacist:		

Physiotherapist / Occupational therapist		
Receptionist, admin		
technical staff		
Other: kitchen, generator, sterilisation, cleaning, maintenance		
Infrastructure:	**Yes/No**	**Comments**
Waiting room		
Reception area		
Triage centre		
Consultant room (number)		
Small Surgery room (number)		
Operation theatre (number)		
Post Op room (number)		
Dressing room (number)		
Obstetrical ward		
Emergency ward		
Intensive Care Unit (number of beds and type)		
Inpatient facilities (number of beds)		
Pharmacy		
Refrigerated vaccine storage		
Blood bank		
X-ray department (specify services)		
Laboratory (specify services)		
Mortuary		
Toilets		
General storage		
Other: groupe 500kVa, cuisine, buande		
Attendance	**Yes/No**	
The hospital attendance hours are 24 h per day, 7 days a week		
The hospital has a system for off-duty physician on call 24/7		
Standards	**Yes/No**	**Comments**
Mandatory Standards (if not compliant, assessment stops here)		
Resuscitation services are available throughout the hospital and contain at least a manual ventilator (bag mask), defibrillator and essential drugs.		
Staff has been trained in Basic and/or Advanced Life support techniques		
Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly, when required.		
A qualified individual(s) is responsible for managing the clinical laboratory service or pathology service.		
A qualified radiologist is available for interpreting results of the exams on site or through teleconsultation or on call		

Is there a business continuity system in place in the case the ICU specialist is not available?		
Does the hospital have a practitioner trained in Comprehensive Gynaecological and emergency obstetrical care (ANC, pregnancy monitoring, complicated deliveries, contraception, preventive care, etc.?)		
UN International Patient Safety Goals	**Yes/No**	**Comments**
1. The hospital has a process to improve accuracy of patient identification (single identification number)		
2. The hospital has a process to ensure that all orders are written and kept in the patient record.		
3. The hospital has a process for reporting critical results of diagnostic tests and critical events.		
4. The hospital has a process for handover communication.		
5. The hospital has a process for ensuring correct-site, correct-procedure, and correct-patient surgery.		
6. The hospital implements WHO Guidelines for Hand Hygiene and Universal Protection in Health Care to reduce the risk of healthcare–associated infections.		
Clinical Focused Standards		
Access to Care (UNAC)		
7. The hospital has a process for admitting patients with emergent needs and does triage on basis of emergency, particularly for children.		
8. At admission as an inpatient, patients receive information on the proposed care and the expected outcomes of care.		
Assessment of Patients (UNAP)		
9. All patients cared for by the hospital have their health care needs identified through an assessment process that has been defined by the hospital.		
10. All inpatients and outpatients are screened for pain and assessed when pain is present.		
11. All patients are reassessed at intervals based on their condition and treatment to determine their response to treatment and to plan for continued treatment or discharge.		
Care of Patients (UNCP)		
12. An individualized plan of care is developed and documented for each patient and is kept in the patient record		
13. The hospital implements a uniform process for prescribing patient orders.		
14. Clinical and diagnostic procedures and treatments performed, and the results or outcomes, are documented in the patient's record.		

15. The care of high-risk patients and the provision of high-risk services are guided by professional practice guidelines, clinical pathways, and policies.		
16. Clinical guidelines and procedures established are implemented for the handling, use, and distribution of blood and blood products.		
17. Patients are supported in managing pain effectively.		
18. The hospital offers OBGYN services compatible with Comprehensive Emergency Obstetrical Care, offering at least surgery for complications of delivery and blood transfusion.		
19. The hospital offers full paediatric services		
Continuity of Care (UNCC)		
20. The hospital carries out processes to provide continuity of patient care services in the hospital and coordination among health care practitioners.		
21. The medical record of the patient's care goes with the patient when transferred within the hospital.		
22. A complete discharge summary is prepared for all inpatients.		
23. Patient education and follow-up instructions are given in a form and language the patient can understand.		
24. The clinical records of inpatients contain a copy of the discharge summary.		
25. The hospital has a process for the management and follow-up of patients who intend to leave against medical advice.		
MEDEVAC		
26. Patients are medevaced to the next level of care based on their medical status, and the ability of the receiving organization to meet patients' needs		
27. The referring hospital follows procedures for the medevac of patients to ensure that patients are transferred safely.		
28. The receiving hospital is given a written summary of the patient's clinical condition and the interventions provided by the referring hospital.		
29. The medevac process is documented in the patient's record.		
Laboratory (basic standards, for full assessment, use form 1b)		
30. Laboratory services are available to meet patient needs.		
31. All laboratory staff members have the required education, training, qualifications, and experience to administer and perform laboratory tests and interpret the results.		

32. The laboratory uses a coordinated process to reduce the risks of infection because of exposure to bio-hazardous materials and waste.		
33. All equipment and medical technology used for laboratory testing is regularly inspected, maintained, calibrated, and appropriate records are maintained for these activities.		
34. The laboratory applies both an internal and external calibration and quality assessment on a daily basis.		
35. The laboratory has sufficient consumables for at least one month of operation		
Radiology		
36. Radiology and diagnostic imaging services are available to meet patient needs, and all such services meet applicable radiation protection measures.		
37. A qualified individual(s) is responsible for managing the radiology and diagnostic imaging services.		
38. A radiation safety program is in place, followed, and documented, and compliance with the facility management and infection control programs is maintained.		
Intensive Care Unit		
39. There is a daily regular attending physician, accredited specialist in Intensive care medicine in the ICU		
40. The ratio of regular attending physicians per bed is at least 1:10 per shift		
41. The ratio of nurses or nurse technicians on duty per bed is at least 1:2 beds per shift		
42. A systematized and regular ICU centred training program is available for professionals before and during assignment to the ICU		
43. There are written protocols for the main emergency pathologies (Stroke, heart attack, trauma, coma, obstetrical and paediatric emergencies, etc.)		
44. There are written protocols for the prevention of main ICU complications (pneumonia, gastro-intestinal bleeding, embolism, etc..)		
45. There are daily multidisciplinary discussions of current cases among all type of staff		
46. There is a monitor and an oxygen dispenser available per bed		
47. There is at least one electrocardiography device per 10 beds		
48. There is at least one transport ventilator (adult and paediatric) per 10 beds		
49. There is at least one crash defibrillator per 5 beds		
50. The ICU conducts prescheduled meetings with relatives of patients to provide information on state of health and care they need		

Anaesthesia and Surgical Care (UNAS)		
51. Sedation and anaesthesia services are available to meet patient needs and are under the supervision of the facility's specialty anaesthetist.		
52. There is a pre-sedation assessment of the patient performed by a qualified professional, under the supervision of the facility specialist anaesthetist.		
53. A qualified individual, under the supervision of the facility specialist anaesthetist, conducts a pre-anaesthesia assessment and pre-induction assessment.		
54. Each patient's anaesthesia care is planned and documented, and the anaesthesia and technique used are documented in the patient's record.		
55. Each patient's physiological status during anaesthesia and surgery is monitored according to WHO professional practice guidelines and documented in the patient's record.		
56. Each patient's post anaesthesia status is monitored and documented, and the patient is discharged from the recovery area by a qualified individual.		
57. Each person's surgical care is planned and documented based on the results of the preoperative assessments, and pre-operative diagnosis is recorded.		
58. The risks, benefits, and alternatives to surgery are discussed with the patient and/or those who make decisions for the patient.		
59. Information about the surgical procedure is documented in the patient's medical record to facilitate continuing care. (See UN-IPSG.3)		
Medication Management (UNMM) basic standards, for full assessment use form 4		
60. A written document identifies how medication use is structured and managed throughout the hospital. Medication use is overseen by a qualified individual.		
61. Medications are properly and safely stored (check visually)		
62. A system is used to safely dispense medications in the right dose to the right patient at the right time.		
63. Medication effects on patients are monitored.		
Administration-Focused Standards		
64. The hospital follows an adverse event reporting process		
65. Patient satisfaction is monitored.		
66. Clinical guidelines and pathways are used to support consistency in care.		
67. The hospital undertakes a prevention and reduction program for health care-associated infection based on the WHO Standard Universal Precautions.		

68. The hospital tracks infection risks, infection rates, and trends in health care-associated infections to reduce the risks of those infections.		
69. The hospital reduces the risk of infections by ensuring adequate medical technology cleaning and sterilization, and the proper management of laundry and linen.		
70. The hospital implements practices for safe handling and disposal of sharps and needles and proper disposal of biomedical waste		
71. Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly, when required.		
72. Leaders evaluate clinical outcome and admission data to support staff performance and track trends over time		
Facility Management and Safety		
73. The hospital facility and buildings are thoroughly inspected to ensure awareness of risks that could affect patients and staff, and to plan for continuously improving the safety of the environment.		
74. There is an SOP and adequate equipment (smoke detectors, fire extinguishers) to ensure that all occupants of the hospital are safe from fire, smoke and other emergencies and simulation takes place.		
75. There is an organized program for the safe management of biomedical equipment and hazardous waste		
76. Safe drinking water and electrical power are available 24 hours a day, seven days a week, through regular or alternate sources, to meet essential patient care needs.		
78. The hospital has developed, maintains, and tests an emergency management program to respond to emergencies and natural or other disasters that have the potential of occurring where the hospital is located.		
79. There is a program to reduce health hazards for staff and to provide safe working conditions		
Staff Qualifications and Education		
80. Technical clearance for all medical service providers and staff has been checked and archived		
81. All physicians, nurses & clinicians follow the ethical code for medical practitioners and the principles of medical ethics.		
82. Staff members who provide patient care are trained in resuscitative techniques (ALS) prior to commencement of staff rotation.		
83. There is a continuous education programme for maintaining and updating skills of staff for the use of clinical pathways and BLS		
Management of Information		

84. Information privacy, confidentiality, and security, including data integrity, are maintained		
85. Records and information are protected from loss, destruction, tampering, and unauthorized access or use.		
86. The medical record contains sufficient information to identify the patient, to support the diagnosis, to justify the treatment, and to document the course and results of treatment		
87. The clinical records of patients receiving emergency care include the time of arrival and departure, the conclusions at termination of treatment, the patient's condition at discharge, and follow-up care instructions.		
88. The hospital has a protocol regarding those who are authorized to make entries in the patient clinical record.		
89. As part of its monitoring and performance improvement activities, the hospital has a clinical record review process to regularly assess patient clinical record content and the completeness of patient clinical records.		

Sources:
UN Manual for Healthcare Quality and Patient Safety, Draft 2018, DPKO
Quality in intensive care units: proposal of an assessment instrument, BioMed Central, 2017

Annex 4: Assessment of Mental Health Services (form 3)

Form 3 : Assessment of Mental Health Facility
(standalone or outpatient facility of a hospital)

Name of facility:
Type of facility:
Registration number :
Date :
Address:

Number of staff:	**Number (full-time equivalent)**	**Comments**
Psychiatrist		
Psychologist		
Child Psychologist		
Medical Doctor		
Other:		

Psychiatrist Nurse:		
Auxiliary Nurse		
Receptionist:		
Other:		
Infrastructure:	**Yes/No**	**Comments**
Waiting room		
Reception area		
Consultant room		
Child friendly room		
Inpatient facilities		
Isolation Unit		
Pharmacy		
Toilets		
General storage		
Other:		
Attendance	**Yes/No**	
The clinic attendance hours are at least 8h per day, 5 days a week		
The clinic has a system for off-duty psychiatrist or Psychologist on call 24/7		
Standards	**Yes/No**	**Comments**
Mandatory Standards (if not compliant, assessment stops here)		
Service users can consult with a psychiatrist (or a medical doctor with at least 2 years of psychiatric training) or a psychologist (or occupational therapist) when they wish to do so		
The following psychotropic medication is available, at all times in sufficient quantity, including paediatric formulations : 1 psychotropic, 1 antidepressant, 1 antianxiety, 1 antiparkinsonian for side effects, 1 Antiepileptic, 1 bipolar disorder drug (mood stabilizor)		
Standards	**Yes/No**	**Comments**
1. The building is in a good state of repair		
2. The necessary resources, equipment are provided by the facility to ensure interaction and participation		
3. Private rooms within the facility are specifically designed for consultation and interview		
4. No person is denied access to facilities or treatment on the basis of economic factors or any other status (gender, religion, ethnicity, etc…)		
5. Everyone who requests mental health treatment receives care in this facility or is referred to another facility		

6. The facility has staff with sufficient diverse skills to provide counseling, psychosocial rehabilitation, prescription, information education and support to service users, family, friends or carers, in particular children		
7. Each service user has an individualized recovery plan that includes his or her social, medical, employment and education goals and objectives for recovery		
8. Recovery plans are driven by the service user, reflect his or her choices and preferences for care, are put into effect and are reviewed and updated regularly by the service users and a staff member		
9. Facilities link users with the general health care system, other levels of health care services or MEDEVAC		
10. Lithium dosage can be tested in the facility or referral laboratory		
11. Service users are informed about the purpose of the medication being offered and any potential side effects		
12. Service users are informed about treatment options that are possible alternatives to complement medication, such as psychotherapy and occupational therapy		
13. Service users preferences are the priority in all decisions about where they will access services		
14. Admission and treatment are based on the free and informed consent of service users		
15. Service users have the right to refuse treatment, except when sectioned under a Mental Health Act		
16. At all times, staff interact with service users in a respectful way, recognizing their capacity to understand information and make decisions and choices		
17. A personal, confidential medical file is created for each service user		
18. Service users have access to information contained in their medical files		
19. Staff members treat service users with humanity, dignity and respect, even in case of contention and electro convulsive therapy		
20. Alternatives to seclusion and restraint are in place and staff are trained in de-escalation techniques for intervening in crises and preventing harm to service users or staff		

Sources:

WHO Quality Rights Tool Kit: Assessing and improving quality and human rights in mental health and social care facilities, Interview Tool, 2012

Annex 5: Assessment of Pharmacy (form 4)

Form 4: Assessment of Pharmacy
(standalone or hospital pharmacy)

Name of facility:
Type of facility (independent or attached to hospital)
Registration number:
Address:
Date:

Number of staffs:	**Number (full-time equivalent)**	**Comments**
Pharmacist		
Auxiliary Pharmacist		
Clerk		
Cashier		
Other:		
Infrastructure:	**Yes/No**	**Comments**
Reception area		
Dispensing counter area		
Preparation area		
Storage room		
Refrigerated area		
Toilet and washroom		
Cashier		
Other: vaccination room etc..		
Attendance	**Yes/No**	
The pharmacy attendance hours are at least 8h per day, 5 days a week		
The pharmacy has a system for off-duty guard system		
Standards	**Yes/No**	**Comments**
Mandatory Standards (if not compliant, assessment stops here)		
Is the pharmacy licensed with the national Regulatory Authority (NRA)?		
Has the pharmacy been inspected within the last year by the NRA		
Is the pharmacist registered by the National Order of Pharmacists or similar body?		

Is there a trained pharmacist or nurse or pharmacy assistant present at all times?		
System		
1. Is a prescription book/computer system available for recording data ?		
2. Does the system provide for recording date, patient, prescriber and drug name?		
3. Are old prescriptions kept (according to national regulations) ?		
4. Does the pharmacy have a formalized stock management system based on stock cards or computerized inventory system?		
5. Does the system enable to calculate/ control reorder levels?		
6. Is stock on hand > 2 months of drug use? (if pharmacy does not have access to daily ordering of drugs)		
7. There has NOT be any stock-out of essential drugs in the last 6 months		
8. Is the time between ordering and receiving drugs < 1 month? (if applicable)		
Storage		
9. Is the facility and the storage room devoid of signs of pests?		
10. Is the dispensing area clean and tidy?		
11. Are there a toilet and hand washing facilities and are they clean and tidy?		
12. Are Medicines protected from direct sunlight?		
13. Are Medicines stored on shelves, systematically, in original packaging, labelled and under lock?		
14. Is temperature monitored and regulated?		
15. Are medicines requiring refrigeration and/or vaccines stored in a refrigerator and temperature monitored?		
16. Are schedule 2 and 3 controlled drugs stored in a locked controlled drug safe?		
17. Is there a procedure for expired drugs and are they stored separately?		
18. Are there SOPs for storage, expiry date checking, dispensing of medicines?		
19. Are stock balances checked against physical stock of drugs at least on a quarterly basis?		
Services		
20. Are opening hours at least 8 h per weekdays?		
21. Are all areas of the pharmacy kept clean, well maintained and kept with hygiene standards?		

Dispensing		
22. Are a drug formulary, catalogues, handbooks or essential drug list available?		
23. Total number of items in stock > 500?		
24. Are there at least 4 different brands or generic cotrimoxazole tablets?		
25. Are there paediatric formulations of the essential drugs?		
26. Are there rapid diagnostic tests for pregnancy, HIV and malaria (if applicable)?		
27. Average dispensing time per patient less than 3 min?		
28. Are drugs dispensed either in original packaging, dispensing envelopes or appropriate containers?		
29. Are clients provided the opportunity of buying the generic version of the drugs on a systematic basis?		
30. Are deliveries counter checked before dispensing?		
Rational drug use		
31. Are patients informed in writing or verbally of the correct dosage, method of administration, duration of therapy and storage of their prescription?		
32. Are the patients informed about severe side-effects, adverse reactions or interactions and action to be taken if they occur (if not prescribed by MD)?		
33. Does the pharmacist always check the prescription?		
34. Would the pharmacy always sell antibiotics with a prescription except in case of emergency?		
35. Does the pharmacy sell antimalarial treatment (CO-Artem) without prescription in case of emergency (if applicable)?		
36. Are the majority (50%) of drugs prescribed dispensed in generic form?		
Management and supervision		
37. Are staff aware of their roles and responsibilities and do they have required qualifications, training and competencies to carry out these roles?		
38. Are there clear, documented procedures for the operation of the pharmacy?		

Sources:
Joint FIP/WHO Guidelines on Good Pharmacy Practice: Standards for Quality Pharmacy Services, October 2009
A new indicator-based tool for assessing and reporting on GPP, Birna Trap et al., Southern Med Review, Vol 3, Issue 2, Oct 2010
Guide to completing the Pharmacy Assessment System, the Pharmaceutical Society of Ireland, October 2016

Annex 6: Mass Casualty Incident Plan (form 5)

Form 5: Mass Casualty Incident Plan

Staff Interviewed
Date
Venue

Documents:	**Yes/No**	**Comments**
UN Security Plan		
Mass Casualty Incident Plan		
MEDEVAC Procedures		
Updated list of contacts		
Updated list of medical facilities		
Updated list of Medical Examining Physicians (MEP)		
Standards	**Yes/No**	**Comments**
Medical Threat and Risk Analysis		
1. Is the MCIP up to date according to the guidelines? List date		
2. Is there a Medical threat and risk analysis in the MCIP?		
3. Is it a Health risk analysis, and specifically reflects medical risks, not security risks?		
4. Has it been developed in a consultative manner with the local security staff and staff association?		
5. Have the UN clinic, UN Medical Services or WHO been involved in the development of the MCIP?		
6. Does the threats analysis include public health crises and occupational health and safety risks?		
7. Does the assessment of likelihood correspond to probability of it happening, and when it might happen, and/or on the historical frequency of it happening		
8. Does the classification correspond to the guidance?		
9. Does the assessment of the impact correspond to the direct medical impact, based on the severity of the injury?		
10. Does the classification correspond to the guidance?		
No scoring, for information: How many risks are unacceptable? Pls specify		
No scoring, for information: How many are very high? Pls specify		
No scoring, for information: How many are high? Pls specify		
11. Has a "Mitigation and residual risk" analysis been performed? By whom?		
12. Have measures been taken to address the Unacceptable, very high and high risks?		
No scoring, for information. Are there any residual risks? Please specify. How have they been assessed?		
*No scoring, for information A*re there any unacceptable residual risks? Which ones?		
13. Have measures be undertaken to address the residual risks been specified?		

14. Have a date and method been specified to address them?		
Health Support Summary (if applicable)		
15. Has a Health support summary been developed?		
16. Does it cover all the critical health support assets available in the duty station?		
17. Does it cover all field duty stations?		
18. Are the UN clinics correctly referenced, according to the guidelines? (if applicable)		
19. Are the hospitals correctly referenced, according to the guidelines for all duty stations? How many?		
20. Has the capacity of the hospitals with dealing with mass casualty been assessed?		
21. Is there an MOU with the referral Hospitals for the implementation of the MCIP?		
22. Are ambulance services correctly referenced, according to the guidelines?		
23. Are there any other disaster management capabilities in the duty station, correctly referenced?		
24. Are all medical services referenced in the plan compliant with the minimal standards, as outlined in the different forms?		
25. Are Mortuary Services referenced? Are there coronial services? Autopsy capabilities?		
26. Are medical evacuation services correctly referenced, according to the guidelines?		
27. Are there any local support arrangements? Specify		
28. Are there any regional support arrangements?		
CONOPS covering specific locations/events (if applicable)		
29. Does the MCIP include an Incident Command System?		
30. Has a CONOPS been developed as part of the MCIP?		
31. Does it cover all the duty stations in the country? Which are missing?		
32. Does it respond to the questions “Who goes where, when do they go there, and what do they do when they arrive ?”		
33. Does the MCIP include a First Responder Response Plan?		
34. Has there been a simulation of the MCIP? When?		
Mass Casualty Incident *Quick Reference Guide (if applicable)*		
35. Has a Quick reference guide been developed?		
36. Does it consider both an on-site and an off-site response team?		
37. Does it consider a senior liaison team?		
38. Does it list the Emergency Medical Contacts, accurately with telephone numbers and alternative contacts?		
39. Does it list the Duty station contacts?		
40. Does it list a crisis management timeline?		
41. Does it list ACTIONS and RESPONSIBLE for the following actions (see list and assess completeness):		
- notification and preparation to move to site		
- activities on site		
- resolution of onsite activity		
- follow up		
42. Are tasks clearly allocated with a clear chain of command?		

43. Are key locations indicated in the QRG? With pictures and maps?		
44. Does it include maps of the duty station? UN compound? Location of offices?		

Source:
Guide on completing MCI plan, UN MSD
Safe Hospital Checklist, WHO, PAHO

Annex 7: Medical Emergency Response (form 6)

Form 6: Medical Emergency Response

Staff Interviewed
Date
Venue

Documents:	**Yes/No**	**Comments**
UN country security plan		
Mass Casualty Incident Plan		
MEDEVAC Procedures or SOPs		
List of Medical Examining Physicians		
Updated list of contacts		
Updated list of medical facilities		
Standards	**Yes/No**	**Comments**
Country Security Plan		
1. Is there a Country Security plan (CSP)? Has it been approved by the SMT?		
2. Does the CSP include a Mass Casualty Incident plan (MCI)?		
3. Has there been a first responder training programme? When? (if applicable)		
4. Has there been a training in basic first aid? Who has been trained?		
5. Does the Duty Station have an inventory of First Aid Kits?		
6. Was the last incident requiring First Aid adequately handled with a positive outcome?		
7. Does the Duty Station have an inventory of PEP kits?		
8. Is there an updated list of PEP kits custodians?		
9. Is there a list of trained practitioners/counselors that can administer the PEP kits?		
10. Has there been a training of first responders? Who has been trained? (if applicable)		

11. Is there a list of trained first responders? How many are they? (if applicable)		
12. Does the Duty Station have an inventory of Emergency Trauma Bag (ETB) equipment (if applicable)?		
13. Have first responders been trained in the use of the ETB? (if applicable)		
14. Does the Duty Station have an inventory of Individual First Aid Kits (IFAK) (if applicable)?		
15. Have first responders been trained in the use of the IFAK? How many? (if applicable)		
CASEVAC (Case evacuation from the field)		
16. Are there any modalities in place for evacuation from a field duty station to the principal duty station or the regional medical centre?		
17. Has the SMT assessed the Medical Emergency Response capability of the duty station?		
18. Does a clear CASEVAC procedure exist for every field duty station? (if applicable)		
19. Have CASEVAC procedures been established with clear command, control and coordination responsibilities?		
20. Are there clear procedures and inventory of facilities capable to provide advanced life support and damage control resuscitation for every field station?		
21. Are there clear procedures and inventory of facilities capable to provide damage control surgery/ ICU?		
22. Does the CASEVAC procedure consider different scenarios (traffic accident, infectious disease, toxic exposure…)		
23. Was the last incident requiring CASEVAC responded to within 24 h?		
24. Did the last incident requiring CASEVAC have a positive outcome?		
MEDEVAC (Medical evacuation to the regional referral center)		
25. Are the administrative instructions for MEDEVAC available?		
26. Does the HOAs have the authority to authorise the MEDEVAC?		
27. Is there an updated list of UN recognized physicians to issue the medical recommendation for the MEDEVAC?		
28.Is the nearest recognized regional medical centre accessible within 24 h ??		
29. Is there an updated list of the points of contact at the regional medical centre?		
30. Is there and SOP for the modalities of transport to the regional medical centre?		
31. Is there an SOP for the authorisation of MEDEVAC by the insurance company?		

32. Is there a centralized reporting system in the Duty Station of the MEDEVACs?		
33. Do both National and International staff have access to MEDEVAC?		
34. Was the last incident requiring MEDEVAC responded to within 72 h?		
35. Did the last incident requiring MEDEVAC have a positive outcome?		
Sources: Casualty Evacuation in the Field, Policy, UNDPKO MEDEVAC, Administrative instructions, Un Secretariat Guidelines on First Responder Programmes, UNDSS		

Annex 8: Assessment of Ambulance Service (form 6b)

Form 6 b: Assessment of Ambulance service (standalone or hospital service)

Name of facility:
Type of facility:
Registration number:
Date:
Address:

Number of staffs:	**Number (full-time equivalent)**	**Comments**
Medical Doctor		
Registered Nurse		
Auxiliary Nurse		
EMC attendant		
EMC Driver		
Other:		
Infrastructure:	**Yes/No**	**Comments**
Reception area		
Garage		
Emergency Communication centre		
Storage room		
Ambulance A1 or A2 (patient transportation)		
Ambulance B (emergency ambulance Basic Life Support)		
Ambulance Type C (Mobile ICU Advanced Life Support)		
Toilet and washroom		
Cashier		
Other: Advanced support car		

Attendance	**Yes/No**	
The service attendance hours are 24/7		
If not 24/7, the service has a system for off-duty personnel on call 24/7		
Standards	**Yes/No**	**Comments**
Mandatory Standards (if not compliant, assessment stops here)		
Resuscitation services are available in each ambulance and contain at least a manual ventilator (bag mask), defibrillator and essential drugs.		
Are there minimum two ambulance personnel at all times for each ambulance?		
Staff has been trained in Basic and Advanced Life support techniques		
Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly, when required.		
Standards		
Service Delivery		
1. Are there documented policies on administrative and technical Standard Operating Procedures (SOP)?		
2. Is there a policy on retention of records and data collection?		
3. Does the ambulance or the service have copies of clinical protocols for most frequent cases?		
Information management		
4. Are Hospital referral forms filled out, secured and confidential?		
5. Is there a Logbook with name, sex and age of patient, name of physician (if applicable) origin and destination, date and time of dispatch and return, reason for transfer, disposition of patient available and used by the crew?		
Safety procedures		
6. Is there a SOP for disinfection and preventive maintenance of the ambulance?		
7. Is there Personal protective equipment for the ambulance crew?		
8. Are there SOPs for the proper disposal of infectious waste, sharps and hazardous substances?		
Staff capabilities		
9. Is there one driver for each shift, with valid professional driving licence and first aid training?		
10. Are the EMT attendants qualified professionals and do they benefit from regular updates and training?		
11. Is there a staff development and continuing education programme?		
Ambulance Body		
12. Are the external markings and lights in conformity with international standards?		

13. Is there an internal separation of the driver from the body of the ambulance?		
14. Are there internal grabrails and adequate and stable cabinets for storing the required equipment?		
Equipment: Basic Life Support		
Check for the presence of the following equipment		
15. (a) one primary, elevating wheeled cot, adjustable to 2 or more levels;		
16. (b) one auxiliary stretcher or stair chair/stretcher combination;		
17. (c) one sterile maternity kit;		
18. (d) one adult bag-valve-mask resuscitator with reservoir;		
19. (e) one paediatric bag-valve-mask resuscitator with reservoir;		
20. (f) one adult traction splint and one paediatric traction splint or one combination adult/paediatric traction splint;		
21. (g) 6 extremity splints in various sizes, disposable or otherwise;		
22. (h) one portable medical oxygen system with a pressure reducing regulator, litre flow control and oxygen supply;		
23. (i) one portable suction unit;		
24. (j) one infant bulb suction in addition to any included in the sterile maternity kit;		
25. (k) one set of sandbags or a head immobilizer;		
26. (l) 2 sets of rigid cervical collars, including a minimum of 4 different sizes in each set;		
27. (m) one upper body immobilizing extrication device;		
28. (n) one bed pan;		
29. (o) one urinal;		
30. (p) 2 K-basins or self-sealing clear plastic emesis bags;		
31. (q) a sufficient number of patient care report forms;		
32. (r) one long spine board with straps;		
33. (s) one scoop stretcher with straps;		
34. (t) one sterile burn kit.		
Equipment Advanced Life Support (if applicable)		
Check for the presence of the following equipment:		
35. a) all the equipment specified under BLS of this standard		
36. b) a portable cardiac monitor/defibrillator;		
37. (c) medications, drugs, I.V. solutions and the equipment necessary for the administration of them;		
38. (d) endotracheal intubation equipment.		
Additional equipment		
39. (a) one set of oropharyngeal airways, sizes 00 through 6;		
40. (b) one adult blood pressure set;		
41. (c) one paediatric blood pressure set;		
42. (d) one stethoscope;		

43. (e) one penlight;		
44. (f) one pair of bandage scissors or super shears;		
45. (g) a supply of sterile 4 x 4s;		
46. (h) a supply of abdominal pads or 4 x 8 dressings;		
47. (i) a supply of clean 4 x 4s;		
48. (j) a supply of roller and triangular bandages;		
49. (k) a supply of adhesive bandages;		
50. (l) a set of hand tools consisting of one combination screwdriver, one 25-cm crescent wrench, one 15-cm pair of pliers, one hammer, and one hacksaw with 3 spare blades;		
51. (m) a supply of tape.		
Communication equipment		
52. Does the ambulance service have an installed Radio communication system (base, vehicle, handheld) ?		
53. Does the ambulance service have a dedicated telephone number and operator?		
Backup-Supervision		
54. Does the ambulance service have a link with an ICU or emergency care unit?		
55. Is there a Medical supervisor of the Ambulance service or a Medical Doctor part of the team?		
Performance		
56. Is the average time between call and arrival at the scene of the patient < 30 min?		
57. Is the average time between call and arrival at the referral hospital < 1 h?		

Source:

Standards of ambulance equipment and supplies» Open Government, Alberta, Canada
Ambulance services performance standards», Kern County Public Health Department, California USA.
Assessment tool for licensing land ambulance and ambulance service provider,
Department of Health, Republic of the Philippines
Prehospital Trauma Care systems, WHO

Annex 9. MHSE Gap analysis/ Risk control tool

MHSE Gap Analysis & Risk Controls							
Duty Station:		Local Provider available and accessible as needed?	If not/partially covered, can current UN capacity compensate?	describe basis for rating.	MHSE appropriately addressed?	Actions needed to fully implement Mandatory Health Support Elements	Risk Controller
	Element Description						
Mandatory Health Support Elements (MHSE)	Primary Care	yes	no		yes		
	Hospital Care	partial	n/a		no		
	Mental Health Services				partial		
	Mass Casualty Plan				n/a		
	Medical Emergency Response						
	Access to pharmaceuticals, incl. PEP						

Note that the assessment forms and the MHSE Gap analysis is available in an excel file which can be accessed under this link….

Annex 10: Terms of Reference MHSE working group

Terms of Reference for the Operations Management Team

Duty Station ……

Assessment of Mandatory Health Support Elements (MHSE)

Background:

The United Nation's High-Level Committee of Management (HLCM) endorsed a Duty Station Health Risk Assessment methodology in Sept. 2017 to assess the health risks at duty stations in a system wide standardized manner.

A Duty Station Health Risk Assessment (DS-HRA) is a core element of Occupational Safety and Health (OSH) to prevent or reduce occupation related injuries, illness, and death of the United Nations personal. The purpose of an HRA in a duty station is to identify the hazards, evaluate the risks and assess the measures already in place and to be put in place, to best prevent and mitigate these risks with the final aim of optimizing the health and safety of the UN employees in the context of the Duty of care responsibility that the UN organization bears towards its personnel. A core component of the DS-HRA is the assessment of the Mandatory Health Support Elements (MHSE) [15] , as these are critical to ensure good quality

[15] Primary Health Care, Hospital Care, Mental Health Services, Mass Casualty Incident plan, Medical

health care to UN staff.

To fast-track health risk assessments, the UNMD has developed tools, templates and guidelines to support consistent, reproducible and transparent self-assessment and health support planning by the duty station/country team. These tools would enable to assess quality of the MHSE in a duty station, either as a standalone process or as part of the DS-HRA. This would support the UN country team to make an informed decision about the model of care for ensuring access to the MHSE as well as confirm a list of preferred providers.

Organizational Setting and Reporting Relationships:

The UNCT in ……. (country) is delegating the authority to the Operations Management Team for implementing the self-assessment of the Mandatory Health Support Elements. This would imply to either consider this as one of the tasks of the OMT in its regular workplan or to set up a dedicated working group tasked with organizing and overseeing this assignement. One of the main tasks of the OMT-WG would be to select and oversee a local assessor/consultant to perform the assessments in the health services catering to UN staff in the country.

The OMT would report back to the UNCT with the output of this assessment and advise it on the Model of Care for UN staff, as well as on the list of preferred providers.

Results Expected:

The purpose of the assignment is to deliver an assessment of all six Mandatory Health Support Elements at xxx (insert the duty station, as well as other field offices….). The output of the assignment would be a Gap Analysis and Risk Control strategy for the MHSE as well as a list of UN Preferred Providers of Health care in xxx (insert duty station and field offices).

Workplan:

Under the lead of the chair of OMT, after delegation by the UNCT, the OMT, or a dedicated working group (OMT-WG), would familiarize itself with the current DS-HRA methodology and the MHSE assessment tools and guidelines. After that, the OMT-WG will develop/review the TORs, publish an advertisement for contracting a local consultant if needed, and select the best candidate. Thereafter, the OMT-WG will brief, supervise the work and the outputs of the consultant and provide support for the implementation of his/her tasks. Finally, the OMT will brief the UNCT on the Gap Analysis and Risk control strategy, advise it on the suggested model of care for UN staff and provide them with a list of preferred providers.

Responsibilities: Within delegated authority, the OMT-WG will be responsible for the following duties:

- Interaction with WHO staff in charge of Health System Development to assess the capacity of the National Regulatory Authorities and decide on the need for a full-fledged assessment
- Develop TORs for a local assessor/consultant, advertise and proceed with the interviews and selection
- Brief the local consultant

Emergencies, and Pharmaceuticals (incl. PEP)

- Approve workplan, supervise consultant and facilitate contacts and logistics
- Participate in a workshop for developing the Gap Analysis and Risk control strategy
- Approve the final report of the consultant
- Brief and advise the UNCT on recommended course of action
- Performs other duties as required.

Core stakeholder groups for communication, engagement and success:

- UNCT
- UN Operations Management Team Members
- Local Security Advisor
- UN staff Associations
- WHO staff in charge of HS development, for selection and oversight of consultant
- **Implementers**: those UN Staff who have a direct role in detailed planning and implementation of specific actions/ initiatives

Duration:

Deadline:

Annex 11. Terms of Reference for Assessor/Consultant

Terms of Reference

For Assessor of Mandatory Health Support Elements (MHSE)

In Duty Station ……

Background:

The United Nation's High-Level Committee of Management (HLCM) endorsed a Duty Station Health Risk Assessment methodology in Sept. 2017 to assess the health risks at duty stations in a system wide standardized manner.

A Duty Station Health Risk Assessment (DS-HRA) is a core element of Occupational Safety and Health (OSH) to prevent or reduce occupation related injuries, illness, and death of the United Nations personal. The purpose of an HRA in a duty station is to identify the hazards, evaluate the risks and assess the measures already in place, or to be put in place; to prevent and mitigate these risks with the aim of optimizing the health and safety of the UN employees in the context of the duty of care responsibility that the UN bears towards its personnel. A core component of the DS-HRA is the assessment of the Mandatory Health Support Elements (MHSE) [16] , as these are critical to ensure good quality health care to UN

[16] Primary Health Care, Hospital Care, Mental Health Services, Mass Casualty Incident plan, Medical Emergency Response and Pharmaceuticals (incl. PEP)

staff.

To expedite health risk assessments, the UNMD has developed tools, templates and guidelines to support consistent, reproducible and transparent self-assessment and health support planning by the duty station/country team. These tools would enable to assess quality of the six MHSE in a duty station, either as a standalone process or as part of the DS-HRA. This would support the UN country team to make an informed decision about the model of care for ensuring access to the MHSE as well as confirm a list of preferred providers.

Organizational Setting and Reporting Relationships:

The Operations Management Team of the UN system in ……. (country) is seeking a public health professional with strong experience in health system management and clinical care and a good knowledge of the UN system. The individual would have to be fluent in (English) (French) (Spanish) (Russian) (Arabic) and the national language. The assessment would be office based with travel around the duty station and to the UN field offices in the country.

The assessor would directly report to UN Operations Management Team (or the OMT task force).

Results Expected:

The purpose of the assessment is to deliver an assessment of all six Mandatory Health Support Elements in ….. at the duty station (as well as field offices….). The output of the assessment would be a gap analysis and risk control strategy for the MHSE as well as a list of UN preferred providers of health care in …. (insert duty station)

Workplan:

Under the lead of the OMT, after familiarization and briefing of current DS-HRA methodology, the MHSE assessment tool and guidelines, and the review of the list of current UN preferred providers, the assessor would submit a workplan and should be able to work with little guidance in the assessment of agreed duty stations.

Responsibilities: Within delegated authority, the assessor will be responsible for the following duties:

- Consultation with the OMT, UN-DSS, UN staff association, to finalize list of providers to be assessed and assess major constraints and problems
- Interaction with WHO staff in charge of Health System Development to evaluate the capacity of the National Regulatory Authorities
- Development of workplan and setting up appointments with providers at duty station and field offices.
- Review of assessments, accreditation and certification of preferred providers by other organisations
- Assessment proper of the different facilities and services

- Facilitating a workshop for developing the Gap Analysis and Risk control strategy
- Develop a final report
- Performs other duties as required.

Core stakeholder groups for communication, engagement and success:

- UN Operations Management Team Members
- Local Security Advisor
- UN staff Associations
- WHO staff in charge of HS development
- **Implementers**: those UN Staff who have a direct role in detailed planning and implementation of specific actions/ initiatives

Duration: to be determined by duty station

Deadline: dito

Competencies:

- **Professionalism:** Ability to identify issues, analyze and participate in the resolution of issues/problems. Ability to conduct data collection using various methods. Conceptual analytical and evaluative skills to conduct independent research and analysis. Ability to apply judgment in the context of assignments given, plan own work and manage conflicting priorities. Shows pride in work and in achievements; demonstrates professional competence and mastery of subject matter; is conscientious and efficient in meeting commitments, observing deadlines and achieving results. Takes responsibility for incorporating gender perspectives and ensuring the equal participation of women and men in all areas of work.
- **Communication**: Speaks and writes clearly and effectively; listens to others, correctly interprets messages from others and responds appropriately; asks questions to clarify and exhibits interest in having two-way communication; tailors language, tone, style and format to match audience; demonstrates openness in sharing information and keeping people informed.
- **Planning & Organizing**: Develops clear goals that are consistent with agreed strategies; identifies priority activities and assignments; adjusts priorities as required; allocates appropriate amount of time and resources for completing work; foresees risks and allows for contingencies when planning; monitors and adjusts plans and actions as necessary; uses time efficiently.
- **Accountability**: Takes ownership of all responsibilities and honors commitments; delivers outputs for which one has responsibility within prescribed time, cost and quality standards; operates in compliance with organizational regulations and rules; provides oversight and takes responsibility for delegated assignments.

Qualifications:

Education*:* Medical doctor or Registered Nurse with an advanced university degree

(Master's degree or equivalent) in management or public health required. Experience in clinical care and/or management of health services. A (para)medical degree in combination with qualifying experience may be accepted in lieu of the advanced university degree.

Experience: Minimum 5 years working in public health, district management, and/or clinical care in field-based location. Demonstrated project management skills, including consultation, co-design and collaboration, managing complex stakeholder groups while achieving deadlines and deliverables. Experience in Accreditation or Quality Improvement of Health Services is an advantage.

Language: The working languages are ……. and ……. For this position fluency in …… and …… is required (both oral and written)

Other: All assessors will be required to sign a confidentiality agreement in the area of work.

Fee: A daily remuneration will be determined based on review of candidates' experience and qualifications as it relates to the expected results and responsibilities outlined above.

Further References

Guidelines on Security Plans, UNDSS, 28 September 2018.

Mass Casualty Incident Plan Templates, UNMD 6 April 2015

Administrative Instructions MEDEVAC, ST/AI/2000/10

Duty Station Health Risk Assessment Standard Operating Procedures and Guidelines

Annex 7. OSH Framework Implementation status of HLCM organizations (20 of the 31 CEB/HLCM organizations) _ August 2019

	Organization	Total scoring	Average	# 1	# 2	# 3	# 4	# 5	# 6	# 7	# 8	# 9	# 10	# 11	# 12	# 13	# 14	# 15	# 16	# 17	# 18	# 19	# 20
1	How far progressed is your organization in implementing an OSH Management System?	0 = work has not started 1 = work has commenced 2 = work is well advanced, but incomplete 3 = work is completed, but not implemented yet 4 = work is fully completed and implemented																					
1.1	There is an appropriately constituted safety and health oversight body (includes senior management, representation of managers, staff, medical services, staff counselors and other appropriate specialists)	40	2	Work is fully completed and implemented	Work is fully completed and implemented	Work has not started	Work is fully completed and implemented	Work has commenced	Work is fully completed and implemented	Work has not started	Work has commenced	Work is fully completed and implemented	Work has not started	Work has commenced	Work has not started	Work has commenced	Work has not started	Work is well advanced, but incomplete	Work is fully completed and implemented	Work is fully completed and implemented	Work is well advanced, but incomplete	Work is fully completed and implemented	Work has not started
1.2	Staff participation in the implementation of the OSH management system through a structure defined by the oversight body.	35	1.75	Work is well advanced, but incomplete	Work is fully completed and implemented	Work has not started	Work is fully completed and implemented	Work has commenced	Work is fully completed and implemented	Work has not started	Work has commenced	Work is fully completed and implemented	Work has not started	Work has commenced	Work has not started	Work has commenced	Work has not started	Work has commenced	Work is fully completed and implemented	Work is fully completed and implemented	Work is well advanced, but incomplete	Work has commenced	Work has not started
1.3	A formal Occupational Safety and Health Policy statement developed and endorsed by the head of the organization	46	2.3	Work is fully completed and implemented	Work is fully completed and implemented	Work has not started	Work is fully completed and implemented	Work is well advanced, but incomplete	Work is fully completed and implemented	Work is well advanced, but incomplete	Work is fully completed and implemented	Work is fully completed and implemented	Work has not started	Work has commenced	Work has not started	Work has not started	Work has not started	Work is fully completed and implemented	Work is fully completed and implemented	Work is fully completed and implemented	Work is fully completed and implemented	Work has commenced	Work has not started
1.4	There is an organisational OSH Policy that meets the requirements of the OSH framework (risk register, incident reporting system)	34	1.7	Work is well advanced, but incomplete	Work is well advanced, but incomplete	Work has commenced	Work is fully completed and implemented	Work is well advanced, but incomplete	Work is well advanced, but incomplete	Work is well advanced, but incomplete	Work is well advanced, but incomplete	Work is well advanced, but incomplete	Work has not started	Work has commenced	Work has commenced	Work has not started	Work has not started	Work is fully completed and implemented	Work is fully completed and implemented	Work is well advanced, but incomplete	Work is well advanced, but incomplete	Work has commenced	Work has not started
2	How far progressed is your organization in Capacity Building?																						
2.1	OSH competencies and training for all members of the organization, staff, managers, senior leadership, safety and health officers and other specialists as appropriate.	33	1.65	Work has commenced	Work is well advanced, but incomplete	Work has commenced	Work is well advanced, but incomplete	Work has commenced	Work is fully completed and implemented	Work has not started	Work is well advanced, but incomplete	Work is fully completed and implemented	Work has commenced	Work has commenced	Work has commenced	Work has commenced	Work has commenced	Work is well advanced, but incomplete	Work is fully completed and implemented	Work has commenced	Work is well advanced, but incomplete	Work is well advanced, but incomplete	Work has not started
3	How far progressed is your organization in development of an Incident Reporting System (IRS)?																						
3.1	There is an IRS for accidents and injuries	46	2.3	Work is fully completed and implemented	Work has commenced	Work has commenced	Work is completed, but not implemented yet	Work is completed, but not implemented yet	Work is fully completed and implemented	Work is fully completed and implemented	Work is fully completed and implemented	Work is fully completed and implemented	Work is fully completed and implemented	Work has commenced	Work has not started	Work has commenced	Work has commenced	Work is completed, but not implemented yet	Work is well advanced, but incomplete	Work is fully completed and implemented	Work has not started	Work is well advanced, but incomplete	Work has not started
3.2	There is an IRS for illnesses, exposures, or less well defined events (near illnesses)	35	1.75	Work is fully completed and implemented	Work has commenced	Work has not started	Work is well advanced, but incomplete	Work is completed, but not implemented yet	Work is fully completed and implemented	Work has not started	Work is fully completed and implemented	Work is fully completed and implemented	Work has not started	Work has commenced	Work has not started	Work has commenced	Work has commenced	Work is fully completed and implemented	Work is fully completed and implemented	Work has commenced	Work has not started	Work has commenced	Work has not started
3.3	There is a capability to collate and analyse incident reporting system data and assign consistent severely measures to incidents that align with risk register methodology.	30	1.5	Work is well advanced, but incomplete	Work has not started	Work has not started	Work is well advanced, but incomplete	Work is completed, but not implemented yet	Work is fully completed and implemented	Work has not started	Work is well advanced, but incomplete	Work is fully completed and implemented	Work is fully completed and implemented	Work has not started	Work has not started	Work has commenced	Work has commenced	Work is fully completed and implemented	Work is well advanced, but incomplete	Work has commenced	Work has not started	Work has not started	Work has not started
3.4	The analysis of IRS data is fed back to the risk register	14	0.7	Work has commenced	Work has not started	Work has not started	Work is completed, but not implemented yet	Work is completed, but not implemented yet	Work has not started	Work has not started	Work has not started	Work has not started	Work has not started	Work has not started	Work has not started	Work has commenced	Work has not started	Work is fully completed and implemented	Work is well advanced, but incomplete	Work has not started	Work has not started	Work has not started	Work has not started
4	How far progressed is your organization in Risk Mapping and implementation of Risk Register?																						
4.1	Sources of data related to OSH have been identified	37	1.85	Work is fully completed and implemented	Work is well advanced, but incomplete	Work has not started	Work is completed, but not implemented yet	Work is completed, but not implemented yet	Work is well advanced, but incomplete	Work has not started	Work has commenced	Work is well advanced, but incomplete	Work has not started	Work is well advanced, but incomplete	Work has commenced	Work has commenced	Work has commenced	Work is fully completed and implemented	Work is well advanced, but incomplete	Work is well advanced, but incomplete	Work is fully completed and implemented	Work has commenced	Work is well advanced, but incomplete
4.2	A risk register has been developed which maps these data sources and identifies key organisational OSH risks (Risk Register)	27	1.35	Work is well advanced, but incomplete	Work is completed, but not implemented yet	Work has commenced	Work is completed, but not implemented yet	Work is well advanced, but incomplete	Work has not started	Work has not started	Work has commenced	Work has not started	Work has not started	Work is well advanced, but incomplete	Work has commenced	Work has commenced	Work has not started	Work is fully completed and implemented	Work is well advanced, but incomplete	Work is well advanced, but incomplete	Work has not started	Work has commenced	Work is well advanced, but incomplete
5	How far progressed is your organization in Risk Assessment and Mitigation?																						
5.1	Identified risks within the risk register have been ranked according to a defined methodology	35	1.75	Work is well advanced, but incomplete	Work is completed, but not implemented yet	Work is well advanced, but incomplete	Work is completed, but not implemented yet	Work is completed, but not implemented yet	Work has not started	Work has not started	Work has commenced	Work has not started	Work has not started	Work has commenced	Work is well advanced, but incomplete	Work is well advanced, but incomplete	Work has commenced	Work is fully completed and implemented	Work is fully completed and implemented	Work has not started	Work has commenced	Work is fully completed and implemented	Work is well advanced, but incomplete
5.2	Identified risks have been prioritized by the organization (or by the oversight body) for action	30	1.5	Work is well advanced, but incomplete	Work has commenced	Work has commenced	Work is well advanced, but incomplete	Work is completed, but not implemented yet	Work is well advanced, but incomplete	Work has not started	Work has commenced	Work is well advanced, but incomplete	Work has not started	Work has not started	Work has commenced	Work is well advanced, but incomplete	Work has not started	Work is well advanced, but incomplete	Work is fully completed and implemented	Work has not started	Work has commenced	Work is fully completed and implemented	Work is well advanced, but incomplete
5.3	Priority risks have had mitigation plans developed/ implemented	27	1.35	Work is well advanced, but incomplete	Work has commenced	Work is well advanced, but incomplete	Work is well advanced, but incomplete	Work is completed, but not implemented yet	Work is well advanced, but incomplete	Work has not started	Work has not started	Work is well advanced, but incomplete	Work has not started	Work has commenced	Work has commenced	Work has not started	Work has not started	Work is well advanced, but incomplete	Work is well advanced, but incomplete	Work has not started	Work has commenced	Work is fully completed and implemented	Work is well advanced, but incomplete
6	How far progressed is your organization in implementing Standards and Compliance?																						
6.1	Arranged supportable standards have been identified that are sustainable for use in the OSH management system	23	1.15	Work is well advanced, but incomplete	Work has not started	Work is fully completed and implemented	Work is completed, but not implemented yet	Work is well advanced, but incomplete	Work has commenced	Work has not started	Work has not started	Work has commenced	Work has not started	Work has commenced	Work has not started	Work has commenced	Work has not started	Work is fully completed and implemented	Work is well advanced, but incomplete	Work has not started	Work has commenced	Work has commenced	Work has not started
6.2	A mechanism exists for promulgation of OSH standards	22	1.1	Work is well advanced, but incomplete	Work has not started	Work is fully completed and implemented	Work is completed, but not implemented yet	Work is well advanced, but incomplete	Work has commenced	Work has not started	Work has commenced	Work has commenced	Work has not started	Work has not started	Work has not started	Work has not started	Work has not started	Work is fully completed and implemented	Work is well advanced, but incomplete	Work has not started	Work has commenced	Work has commenced	Work has not started
6.3	Standards compliance is measured and reported back to the oversight body	12	0.6	Work has commenced	Work has not started	Work has not started	Work has commenced	Work is well advanced, but incomplete	Work has not started	Work has not started	Work has not started	Work has not started	Work has not started	Work has not started	Work has not started	Work has not started	Work has not started	Work is well advanced, but incomplete	Work is fully completed and implemented	Work has not started	Work has commenced	Work has commenced	Work has not started
7	How far is your organization in the process to provide																						
7.1	Appropriate internal and external communication to ensure OSH matters are received, documented and responded appropriately.	31	1.55	Work has commenced	Work has commenced	Work is fully completed and implemented	Work is well advanced, but incomplete	Work is well advanced, but incomplete	Work is fully completed and implemented	Work has commenced	Work is well advanced, but incomplete	Work is well advanced, but incomplete	Work has not started	Work has not started	Work has not started	Work is well advanced, but incomplete	Work has not started	Work is fully completed and implemented	Work is well advanced, but incomplete	Work has commenced	Work has commenced	Work is well advanced, but incomplete	Work has not started
7.2	Sufficient resources to implement the OSH management systems.	21	1.05	Work has commenced	Work has not started	Work is well advanced, but incomplete	Work has commenced	Work has commenced	Work has commenced	Work has not started	Work has commenced	Work has commenced	Work has not started	Work has commenced	Work has not started	Work has commenced	Work has not started	Work is well advanced, but incomplete	Work is well advanced, but incomplete	Work is fully completed and implemented	Work has commenced	Work is well advanced, but incomplete	Work has not started
7.3	An occupational health capability with primarily preventive functions and the individual management of staff whose health is at risk or actually harmed by way of their employment in the organization	34	1.7	Work has commenced	Work has commenced	Work is fully completed and implemented	Work is well advanced, but incomplete	Work has commenced	Work has commenced	Work has not started	Work is fully completed and implemented	Work has commenced	Work has not started	Work is fully completed and implemented	Work has commenced	Work has commenced	Work has commenced	Work has commenced	Work is fully completed and implemented	Work is fully completed and implemented	Work has commenced	Work is well advanced, but incomplete	Work has not started
7.4	An occupational safety capability that aids in hazard identification and reduction and risk assessment and mitigation.	29	1.45	Work is well advanced, but incomplete	Work has commenced	Work has commenced	Work is completed, but not implemented yet	Work has commenced	Work has commenced	Work has not started	Work is fully completed and implemented	Work has commenced	Work has not started	Work has commenced	Work has not started	Work has commenced	Work has commenced	Work is fully completed and implemented	Work is fully completed and implemented	Work has commenced	Work has commenced	Work is well advanced, but incomplete	Work has not started

Annex 8. Monitoring and Evaluation: Implementation status in UN organizations, August 2019

Organization	FAO	IAEA	IFAD	ILO	IOM	UN Habitat	UN Secretariat	UN Women	UNDP	UNESCO	UNFCCC	UNFPA	UNHCR	UNICEF	UNIDO	UNOPS	UNV	WFP	WHO	World Bank Group	WIPO
Do you provide a pre-deployment guide as part of your induction programme to staff deployed to high-risk locations?	In Progress	Not applicable (for organizations with no presence in high-risk locations)	Yes	In Progress	In Progress	No	Yes	In Progress	In Progress	Yes	Not applicable (for organizations with no presence in high-risk locations)	In Progress	In Progress	Yes	In Progress	In Progress	Yes	Yes	In Progress	Yes	In Progress
Do you provide or plan to provide a pre-deployment guide to other personnel in high-risk locations? Please explain.	In Progress	Not applicable (for organizations with no presence in high-risk locations)	Yes	In Progress	In Progress	No	Yes	In Progress	In Progress	Yes	Not applicable (for organizations with no presence in high-risk locations)	In Progress	In Progress	Yes	In Progress	In Progress	Yes	In Progress	In Progress	Yes	In Progress
Do you provide or plan to provide a pre-deployment guide also to staff and other personnel in non-high risk locations (for example, prior to official duty travel)?	In Progress	Not applicable (for organizations with no presence in high-risk locations)	Yes	In Progress	In Progress	No	Yes	In Progress	In Progress	In Progress	Not applicable (for organizations with no presence in high-risk locations)	In Progress	In Progress	Yes	Yes	No	Yes	In Progress	In Progress	Yes	No
Have you embedded the pre-deployment guide, developed by the Task Force, into your induction programme?	In Progress	Yes	No	No	In Progress	No	In Progress	No	In Progress	No	No	In Progress	In Progress	Yes	In Progress	In Progress	In Progress	Yes	No	Yes	No
Do you provide briefings to enhance staff resilience in the new duty station (i.e. resilience briefings) to all staff deployed to high-risk locations?	Yes	Not applicable (for organizations with no presence in high-risk locations)	Yes	In Progress	In Progress	No	Yes	In Progress	Yes	Yes	Not applicable (for organizations with no presence in high-risk locations)	In Progress	Yes	Yes	No	No	Yes	Yes	In Progress	Yes	No
Do you provide or plan to provide resilience briefings to other personnel in high-risk locations? Please explain.	In Progress	Not applicable (for organizations with no presence in high-risk locations)	Yes	No	In Progress	No	Yes	No	In Progress	Yes	Not applicable (for organizations with no presence in high-risk locations)	No	Yes	Yes	Yes	No	Yes	No	In Progress	Yes	No
Do you provide or plan to provide resilience briefings also to staff and other personnel in non-high risk locations?	In Progress	In Progress	Yes	No	Yes	In Progress	Yes	No	In Progress	Yes	Yes	No	Yes	Yes	In Progress	No	No	No	No	Yes	In Progress
Do you have country-specific factsheets for all high-risk locations?	Yes	Not applicable (for organizations with no presence in high-risk locations)	Yes	Yes	No	Some	Yes	Some	Some	Yes	Not applicable (for organizations with no presence in high-risk locations)	Some	Yes	Some	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Do you provide specific managerial training to your staff (including locally-recruited staff) in high-risk locations?	In Progress	Not applicable (for organizations with no presence in high-risk locations)	No	In Progress	In Progress	No	Yes	No	No	No	Not applicable (for organizations with no presence in high-risk locations)	In Progress	Yes	In Progress	Yes	No	Not applicable (for organizations with no presence in high-risk locations)	Yes	Yes	Yes	Yes
Do you provide or plan to extend the managerial training to other personnel?	Yes	Not applicable (for organizations with no presence in high-risk locations)	No	In Progress	Yes	No	Yes	Yes	No	No	Not applicable (for organizations with no presence in high-risk locations)	In Progress	Yes	In Progress	Yes	No	Not applicable (for organizations with no presence in high-risk locations)	In Progress	Yes	Yes	Yes
Do you have a mechanism to provide continuous support to managers who are serving in high-risk locations?	Yes	Not applicable (for organizations with no presence in high-risk locations)	Yes	Yes	In Progress	No	Yes	Yes	In Progress	Yes	Not applicable (for organizations with no presence in high-risk locations)	In Progress	Yes	Yes	Yes	Yes	Not applicable (for organizations with no presence in high-risk locations)	In Progress	Yes	Yes	Yes
Do you have a process for Country Offices to request and receive support to implement health support plans, following Duty Station Health Risk Assessments or a Mandatory Health Support Self-Assessment?	In Progress	In Progress	Yes	Yes	In Progress	No	Yes	In Progress	No	Yes	No	No	Yes	In Progress	In Progress	In Progress	No	Yes	Yes	Yes	No
Have you implemented online claiming for medical insurance for staff?	Yes	Yes	Yes	In Progress	Yes	Yes	Yes	Yes	Yes	Yes	Yes	In Progress	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Have you implemented online claiming for medical insurance for other personnel?	No	No	Yes	No	No	No	Yes	Yes	Yes	No	No	Yes	In Progress	No	Yes	Yes	Yes	Yes	Yes	No	Yes
Have you made information on compensation for service incurred illness, injuries or death (e.g. Appendix D to the UN Staff Regulations and Rules), manager's guide for this compensation and relevant forms available on your intranet?	Yes	Yes	Yes	No	Yes	Yes	Yes	In Progress	Yes	Yes	Yes	In Progress	Yes	In Progress	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Have you appointed a focal point to manage cases related to compensation for service incurred illness, injuries or death (e.g. Appendix D to the UN Staff Regulations and Rules) and made their contact information available on your intranet?	Yes	Yes	Yes	No	Yes	No	Yes	In Progress	Yes	Yes	Yes	In Progress	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
What percentage of payments are paid to beneficiaries within 60 days of the receipt of all documents?	100	0	100	1	100	44	100	100	100	80	0	100	75	50	80	0	100	50	100	80	100
Do you have administrative measures to allow staff and other personnel to receive the necessary medical services from any type of UN clinics?	Yes	Not applicable (for organizations that do not have presence in locations where there are UN clinics)	Yes	No	In Progress	Yes	In Progress	Yes	Yes	Yes	Not applicable (for organizations that do not have presence in locations where there are UN clinics)	No	Yes	In Progress	In Progress	In Progress	Yes	Yes	Yes	Yes	Yes
Have you developed measures and/or communication efforts to assist staff to update their beneficiaries forms?	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Do you have an internal processes for claiming Malicious Acts Insurance Policy (MAIP) compensation?	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Do you have a process to verify that affiliate personnel (i.e. individuals with direct contractual relationship with the UN organization, e.g. individual contractors, consultants etc.) have appropriate insurance coverage prior to deployment to high-risk locations?	Yes	Not applicable (for organizations with no presence in high-risk locations)	Yes	No	Yes	Yes	Yes	No	In Progress	In Progress	Not applicable (for organizations with no presence in high-risk locations)	In Progress	In Progress	Yes	Yes	Yes	Not applicable (for organizations with no presence in high-risk locations)	Yes	No	Yes	Yes

Organization	FAO	IAEA	IFAD	ILO	IOM	UN Habitat	UN Secretariat	UN Women	UNDP	UNESCO	UNFCCC	UNFPA	UNHCR	UNICEF	UNIDO	UNOPS	UNV	WFP	WHO	World Bank Group	WIPO
Do you have or plan to have a process to verify that affiliate personnel (i.e. individuals with direct contractual relationship with the UN organization, e.g. individual contractors, consultants etc.) also have appropriate insurance coverage in non-high risk locations?	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	In Progress	Yes	In Progress	In Progress	Yes	Yes	Yes	Yes	Yes	In Progress	Yes	Yes
Do you have policies, procedures or guidance reflecting the HLCM-endorsed "UN minimum living and working standards in high-risk environments"?	No	No	Yes	Yes	Yes	Yes	Yes	In Progress	No	Yes	No	In Progress	Yes	In Progress	In Progress	Yes	No	Yes	No	Yes	In Progress
Are you implementing "UN minimum living and working standards" for your new accommodations and office premises in high-risk locations?	No	Not applicable (for organizations with no presence in high-risk locations)	Yes	In Progress	Yes	Yes	Yes	Yes	In Progress	Yes	Not applicable (for organizations with no presence in high-risk locations)	Yes	Yes	In Progress	Yes	Yes	Not applicable (for organizations with no presence in high-risk locations)	Yes	No	Yes	Yes
Have you established a plan to renovate existing accommodations/office premises to bring into compliance with "UN minimum living and working standards"?	No	Not applicable (for organizations that do not have field-based accommodations)	Yes	No	Yes	Yes	No	In Progress	No	No	Not applicable (for organizations that do not have field-based accommodations)	No	Yes	In Progress	No	Yes	Not applicable (for organizations that do not have field-based accommodations)	Yes	No	Yes	Yes
Are you monitoring the status of living and working conditions in high-risk locations on at least an annual basis?	No	Not applicable (for organizations with no presence in high-risk locations)	Yes	No	Yes	Yes	In Progress	Yes	No	Yes	Not applicable (for organizations with no presence in high-risk locations)	In Progress	Yes	Yes	No	Yes	Not applicable (for organizations with no presence in high-risk locations)	Yes	No	Yes	In Progress
Are you applying or do you plan to apply the "UN minimum living and working standards in high-risk environments" also in all other non-high risk locations?	No	Yes	Yes	No	Yes	No	In Progress	In Progress	No	No	No	No	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes
Have you established a plan to bring existing living accommodations/office premises in compliance with bandwidth requirements for staff and other personnel?	Yes	Yes	Yes	In Progress	Yes	No	Yes	In Progress	No	Yes	Yes	In Progress	Yes	Yes	In Progress	Yes	Yes	In Progress	Yes	Yes	Yes
Are you monitoring the status of bandwidth in the duty station for personal use (e.g. connecting with family, tele-health services, etc.) on at least an annual basis?	Yes	Yes	Yes	No	No	Yes	Yes	In Progress	Yes	In Progress	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	In Progress
Have you adopted and begun implementation of the Mental Health Strategy?	In Progress	Yes	Yes	In Progress	Yes	Yes	In Progress	Yes	Yes	No	No	In Progress	Yes	Yes	No	No	In Progress	Yes	In Progress	Yes	Yes
Have you conducted the necessary actuarial studies to make decisions regarding medical travel for eligible staff and families to secure essential medical care for chronic medical conditions requiring medical intervention that is unavailable or inadequate in the duty station?	Yes	Not applicable (for organizations with no presence in field-based locations)	Yes	Yes	No	In Progress	No	No	No	No	Not applicable (for organizations with no presence in field-based locations)	No	Yes	No	In Progress	Yes	No	No	Yes	Yes	Not applicable (for organizations with no presence in field-based locations)
Have you established or revised policies regarding medical travel for eligible staff and families to secure essential medical care for chronic medical conditions requiring medical intervention that is unavailable or inadequate in the duty station?	Yes	Not applicable (for organizations with no presence in field-based locations)	Yes	Yes	In Progress	Yes	In Progress	No	Yes	In Progress	Not applicable (for organizations with no presence in field-based locations)	No	Yes	In Progress	In Progress	No	No	Yes	Yes	Yes	In Progress
Have you established a mechanism to provide administrative and financial support to Country Representatives to provide additional residential safety and security measures for locally-recruited staff upon SMT recommendation?	Yes	Not applicable (for organizations with no presence in field-based locations)	Yes	Yes	No	Yes	No	In Progress	Yes	Yes	Not applicable (for organizations with no presence in field-based locations)	Yes	Yes	In Progress	Yes	Yes	Not applicable (for organizations with no presence in field-based locations)	Yes	Yes	Yes	Yes
Have you established a mechanism to provide administrative and financial support to Country Representatives to enable them to provide additional measures to ensure safe transportation for locally-recruited staff upon SMT recommendation?	Yes	Not applicable (for organizations with no presence in field-based locations)	Yes	No	In Progress	Yes	No	No	Yes	Yes	Not applicable (for organizations with no presence in field-based locations)	Yes	Yes	In Progress	Yes	Yes	Not applicable (for organizations with no presence in field-based locations)	Yes	Yes	Yes	Yes
Do you provide first-aid and medical essential kits in high-risk locations as per Medical Services and/or SMT recommendation?	Yes	Not applicable (for organizations with no presence in field-based locations)	Yes	In Progress	Yes	Yes	No	In Progress	In Progress	Yes	Not applicable (for organizations with no presence in field-based locations)	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Do you provide or plan to provide first-aid and medical essential kits also in non-high risk locations as per Medical Services and/or SMT recommendation?	Yes	Yes	Yes	In Progress	Yes	Yes	No	In Progress	In Progress	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Have you developed a mechanism to address and/or provide measures for staff who can no longer serve in high-risk locations, due to reasons affecting their physical or mental health?	In Progress	Not applicable (for organizations with no presence in field-based locations)	Yes	Yes	In Progress	No	Yes	Yes	Yes	Yes	Not applicable (for organizations with no presence in field-based locations)	In Progress	Yes	No	Yes	No	No	Yes	In Progress	Yes	Not applicable (for organizations with no presence in field-based locations)
Have you developed a mechanism to also address and/or provide measures measures for staff who can no longer serve in non-high risk locations, due to reasons affecting their physical or mental health?	In Progress	Yes	Yes	In Progress	In Progress	No response	Yes	Yes	Yes	Yes	No	In Progress	Yes	No	Yes	No	No	Yes	Yes	Yes	In Progress
Do you provide transportation for locally-recruited staff based in field offices to the nearest urban town or capital city to allow these staff members to spend their time-off at a location where basic services are available?	No	Not applicable (for organizations with no presence in field-based locations)	No	No	No	No response	No	No	Yes	No	Not applicable (for organizations with no presence in field-based locations)	In Progress	Yes	Yes	No	No	Not applicable (for organizations with no presence in field-based locations)	No	Yes	In Progress	Not applicable (for organizations with no presence in field-based locations)

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Do you have flexible solutions to provide basic essential and standby supplies to staff and other personnel that are difficult to obtain in high-risk locations?	No	Not applicable (for organizations with no presence in high-risk locations)	Yes	No	No	In Progress	Yes	No	No	Yes	Not applicable (for organizations with no presence in high-risk locations)	No	In Progress	In Progress	Yes	No	Not applicable (for organizations with no presence in high-risk locations)	Yes	Yes	Yes	Not applicable (for organizations with no presence in high-risk locations)
Do you have or plan to have flexible solutions to also provide basic essential and standby supplies to staff and other personnel that are difficult to obtain in non-high risk locations?	No	Yes	Yes	No	No	No	Yes	No	No	No	No	No	Yes	In Progress	Yes	No	No	Yes	Yes	Yes	No